While thus gentle Maid thy soft smiles I am courting
What raptures thy beauties impart,
For one glance from that eye, while the Cupids are sporting
Is worth millions of worlds to my heart

My fond heart it can scarce its wild tenant restrain
Transported by charms so divine,
Hark! it beats, and will burst from this bosom to gain
Acceptance to thee, Valentine

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Harvard Medical Alumni Bulletin

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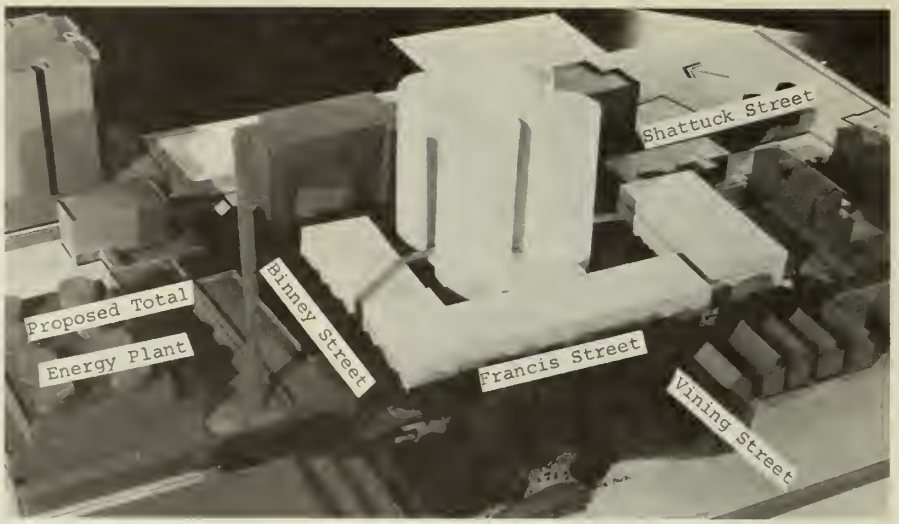
Cover: This rare English bird-cage valentine of 1840 speaks gallantly of virtuous love. Today, valentines speak more boldly of carnal love. The upshot of more liberated attitudes towards sexuality affects the physician especially as he or she is turned to for more than just solace. The physician must develop professional expertise with which to care for patients with psychological and physiological sexual problems as well as those who would simply like to talk informally about sex. In this issue Dr. Carol Nadelson, a member of the faculty, and Raymond Babineau '63, who teaches at the University of Rochester School of Medicine, probe both the physician's role in these delicate matters and how sexuality can be integrated into a medical curriculum. Also along curricular lines, starting on p. 16 are articles about several different programs initiated by the department of preventive and social medicine for students who want a taste of medical practice beyond HMS.

Credits: cover and p. 11 (top left), Rustcraft Greeting Cards; p. 2, 4 (bottom), 27, 33, David Gunner; map p. 3, Joseph Oricko; p. 4 (top), Dick Lewis; p. 7, Edward Mason, M.D.; p. 11, Roz Gerstein; p. 13, courtesy of the Women's Yellow Pages; p. 15, Linda Covell '73; p. 19, 23, Indian Health Service; p. 20-22, Human Relations Area Files; p. 24 (top), Deborah Miller, (bottom left), Klaus Bruckhardt, (bottom right), Images Photography; p. 29, Gwen Frankfeldt; p. 40, courtesy of Norman Geschwind '51.

Overview



Above: A model of the area that is the site of the Affiliated Hospitals Center, the proposed total energy plant, and in the lower lefthand corner, the MASCO Service Center. Opposite right: a drawing of the AHC tower.

AHC — a significant merger

Groundbreaking ceremonies for the Affiliated Hospitals Center (AHC) took place on December 20 in the parking lot behind the Peter Bent Brigham Hospital, the site of the future hospital. Witnessing the occasion were Ambassador Henry Cabot Lodge; Robert Parks, president of Roxbury Tenants of Harvard; Dan Welden, president, Mission Hill Planning Commission; and Herbert P. Gleason, corporation counsel, city of Boston. Guest speaker was John H. Knowles, M.D., president of the Rockefeller Foundation, who said in his remarks, "Combining the strengths of three great Harvard hospitals, the AHC will play a vital role in regional planning for health services which can only redound benefits to the community in terms of cost, quality, and accessibility of these crucial human services."

The hospital complex — that optimistically will be totally operative in five years at a cost of $129 million is a far different one than was envisioned when Dean George P. Berry first proposed a colossal Harvard Medical Center back in the mid-1950s that would cost $50 million and would include: the Countway Library, two buildings of the School of Public Health, two new wings to existing buildings, renovation of the structures in the Quadrangle, and a hospital complex uniting six of Harvard's teaching hospitals. Elaborate plans afooot in 1960 to make Boston the "Athens of Medicine" were forestalled and eventually discarded through a series of cumulative and complex related factors — environmental, economic, political, and social.

Originally, the Peter Bent Brigham, Children's, the Boston Lying-in, the Robert B. Brigham Hospitals, the Free Hospital for Women, and part of the Massachusetts Eye and Ear Infirmary were to parlay resources and facilities into a unified hospital center with the Harvard Medical School at its vortex. The Massachusetts Eye and Ear stepped out of the group, choosing instead to rebuild at its own location. Children's Hospital also was unable to indefinitely postpone a starting date for construction, and went ahead on its own. That left three instead of six institutions (the Free Hospital for Women became the Parkway Division and consolidated with the Lying-in in 1966 to form the Boston Hospital for Women). In the intervening fifteen years, the Peter Bent Brigham conducted its own modest rebuilding program.

The reincarnation of Dean Berry's concept for a hospital complex came to be known as the Affiliated Hospitals Center, which was incorporated in 1962 though without any further development until an office was established in 1967 for this "Joint Venture." The merger between the PBBH, RBBH, and BHW, which was initiated in 1973, was not accomplished until January 1, 1975. The complex will rise on the site of Harvard-owned land — the area bounded by Binney, Francis, and Shattuck Streets. Bertrand Goldberg Associates of Chicago are the architects of the four-leaf clover shaped sixteen-story tower. The typical medical/surgical floor will be arranged with sixty beds divided into four circularly-shaped pods of fifteen beds each. Two levels underneath the tower will be for direct patient support services — surgery, labor/delivery, neonatal intensive care, x-ray, central supply, and kitchen. Paralleling the tower along Binney and Francis Streets will be situated the laboratories and adjacent to this will be a separate three-story ambulatory care building. Across from Binney Street, and enclosed by Francis Street, Peabody Road, and Brookline Avenue, Harvard plans to build a much-contested power plant to serve both the Affiliated buildings and the Mission Park Housing Development that is being constructed on the former Vining Street parking lot and other Harvard property that borders on Huntington Avenue.

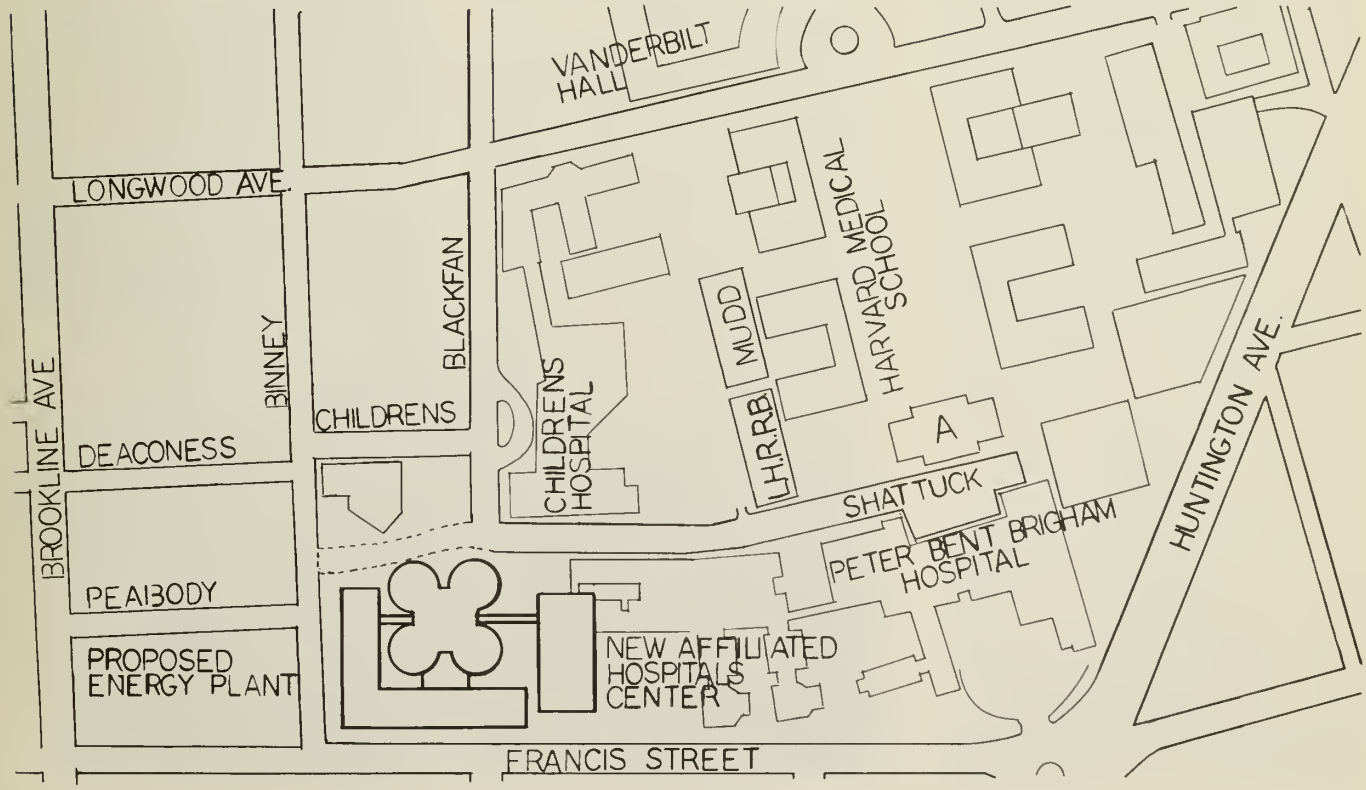
The fact that community housing is being constructed on property leased by Harvard and utilizing Harvard's energy resources attests to the emergence of undaunted community action as a force that the aspiring Affiliated Hospitals Center has had to reckon with over the past few years. Although their groundbreakings were not held simultaneously (the housing development's took place on October 17), these two entities are more than just coincidentally related. A large measure of community opposition to the AHC subsided once Harvard joined with community groups as an equal partner in the housing development. Of the 775 units, 500 are designed for low- and moderate-income families, and the remaining 275 will be rented at current market rates. Harvard is also committed to a $620,000 renovation program of

other neighborhood dwellings and to subsidizing the relocation expenses of the people involved. The development, which has been financed by the sale of state-guaranteed notes for the $39 million mortgage from the Massachusetts Housing Finance Agency, is expected to be completed in the spring of 1978. An attached underground garage will be able to accommodate 1294 cars and space for another 700 will eventually be available at an adjacent materials-handling site. Recreational facilities are to include a swimming pool, tennis and basketball courts as well as a community building with other facilities and medical office space.

Under the auspices of the Medical Area Service Corporation (MASCO), Harvard will supply free heat and utilities for both housing and hospital once the $56 million energy plant is finished. Even though the area for the power plant has been partially cleared away, further work has been halted until the Massachusetts Secretary of Environmental Affairs approves the required study by Harvard evaluating the environmental impact of the plant on the surrounding areas. There are still some in the community who object to this particular construction, which is authorized by Harvard, but obviously related to the AHC. Realizing the importance of the environment — traffic patterns, parking, noise, pollution, and aesthetics — the Affiliated has established an impact monitor committee for the duration of the construction in the Medical Area.

Fifteen years ago, when the idea for a large-scale Harvard hospital complex was proposed, concern about the environment — and especially the urban environment — was negligible. Gradually, people became aware of the implications of immense structures for neighborhood design, and residents began to exercise their option to protect their interests. As a result, several dramatic changes have been made in the design of the AHC; it metamorphosed from a twenty-eight to a sixteen-story tower, for one. The community also protested the expansionist nature of the construction and managed to obtain agreement from Affiliated officials that the hospital will stay within defined perimeters. Initially this was to prevent the hospital from displacing residents for future construction purposes. Although the hospital will be confined to one side of Francis Street only, MASCO intends to build a service center, after the hospital is completed, across the street and partway up the first block of Francis Street, which will be connected to the tower through an underground tunnel. As the executive vice president Richard D. Wittrup noted, the final structural outcome of the AHC is a combination of "good urban planning and community objections."

The concept of standardization and review processes for new hospital facilities was still quite nebulous when the hospital started to become more tangible. By 1972, the state was requiring that any new hospital construction had to be approved by the Public Health Council and awarded a Certificate-of-Need, which occurred for the Affiliated in April 1974. To comply with Massachusetts law, the number of beds was pared down from a high of 789 to 680 — less than the replacement level.



A model of the Mission Park Housing Development, which faces on Huntington Avenue.

At that time, the community — represented by the Roxbury Tenants of Harvard and the Mission Hill Planning Commission — took a position on the offensive to call into question the basic premise of the AHC as a Harvard teaching hospital and how it was expected to relate to the people living in close proximity to it. These groups took issue with the AHC because they believed that the hospital, which will hold such a dominant place in the community, should be obligated to provide optimum care for the area's population. It had become apparent to many people, including many physicians, that primary care physicians have not been as plentiful as specialists. The Mission Hill community wanted the hospital to offer substantial primary care services directly benefitting the local residents. Negotiations with community activists eventually led to the AHC and Harvard recognizing, if somewhat belatedly, the claims of the community as legitimate. The blueprints for the AHC now include an ambulatory/primary care center, reflecting the concern of neighborhood people about hospital policy decisions that will ultimately affect them. Future input from local groups will come from community participation in the governance of the primary care center, which can then be channeled to the AHC board of trustees before decisions are made. Concerted efforts by individuals on both sides have led the way to community representation equal to that of the hospital on the proposed standing committee of the board of trustees; five additional members will constitute a public class of trustees on the board itself. According to hospital spokesmen, the Affiliated will implement a changing "emphasis of clinical teaching at Harvard Medical School towards primary care." The primary care building, however, will be included in the second stage of the total $129 million construction. As only fifteen per cent of the total capital has been amassed, and the first part of the construction is expected to cost $55 million, there is some skepticism on the part of the community that the primary care facility will be erected because of its lowered priority. However, new inpatient beds, which are most urgently needed, will vacate space in the Peter Bent Brigham, which can then be temporarily allocated for primary care services while the first stage of construction is in progress. In addition to the open wards of the PBBH, the Robert B. Brigham, which is being sold to the New England Baptist Hospital, and the Parkway Division of the Boston Hospital for Women will move into their new quarters during this initial phase. The Lying-in Division will move in the second stage because its labor and delivery facilities will occupy an area that cannot be cleared until after the first stage and because its own ambulatory program will move into the ambulatory care building, which will be located on the land where the open wards of the PBBH are at present.

When the "host" community of Mission Hill and officials of the AHC agreed to these various stipulations in principle nearly two years ago regarding certain characteristics of the AHC, the hospital was then able to obtain its Certificate-of-Need. Both sides are now reconciled to what has been a momentous, but surely not a simple collaboration. Mission Park Housing Development and the Affiliated Hospitals Center together will generate several thousand jobs, and it is hoped will complement each other and the Harvard Medical School.

Prophecy fulfilled

As it was foretold by Aesculapians of HMS '40, "The sun will still glint on/The dome of Bob Linton/When the Brigham has crumbled to dust." Here the MGH's own incomparable Robert R. Linton '25, former assistant clinical professor of surgery, contemplates the scene of destruction from which the Affiliated Hospitals Center will rise. (actually the parking lot of the Brigham, not the main building). Friends and former pupils will be pleased to know that Dr. Linton, now fully recovered from a serious auto accident, is again at work in the operating room on a regular basis.

HMS alumni reception at ACP

At the annual meeting of the American College of Physicians, a reception for Harvard Medical alumni who will be in attendance will be held Tuesday, April 6, 1976 from 5:30 to 7:00 p.m. in the North Cameo Room at the Bellevue Stratford Hotel.

We will be looking for you.

Reid named to Wolbach chair in pathology

Lynne Reid, M.D., a pulmonary morphologist of world renown, has been appointed the Wolbach Professor of Pathology at HMS and pathologist-in-chief at The Children's Hospital Medical Center.

Dr. Reid

A native of Australia, Dr. Reid is currently professor of experimental pathology at London University and director of the department of experimental pathology and dean of the Cardiothoracic Institute, Brompton Hospital, London University. In her research, she has made major contributions to the anatomy, radiology, and clinical picture of emphysema. Since 1967, she has concentrated on the normal and abnormal development of the respiratory apparatus, publishing a series of studies on the relationship between pulmonary circulation and pulmonary disease, particularly cystic fibrosis, congenital heart disease, and primary pulmonary hypertension. She currently serves on the editorial committees of the *Bulletin de Physio-Pathologie Respiratoire* and *Biorheology*.

Also noted as a teacher, Dr. Reid has delivered learned lectures in both England and the US. In 1965 she was named the first Hastings Visiting Professor in Pathology at the University of California, Los Angeles, School of Medicine; and in 1971 she served as the Walker-Ames Professor at the University of Washington, Seattle. The Canadian Thoracic Society made her its first Honorary Fellow in 1973.

Dr. Reid is the successor of the late Sidney Farber '27 as incumbent of the Wolbach Chair. A gift from The Children's Hospital Medical Center in 1967 made possible the establishment of the chair, in honor of the memory of Simeon Burt Wolbach, M.D., who was professor of pathological anatomy at HMS from 1922 to 1947, becoming professor emeritus in 1947.

"Healers of Our Age" exhibit/portfolio

The Boston Medical Library has received a handsome gift on the occasion of its centennial — and one which it is hoped will yield many other generous gifts to the BML in the future. The renowned Canadian portrait photographer, Yousuf Karsh, and his wife Estrellita, a noted medical writer, have created "Healers of Our Age": a series of portraits of "men and women devoted to the science and art of healing," with accompanying text. The Polaroid Corporation has joined in the effort by donating all the film and the costs of printing and shipping.

The framed photographic portraits are currently on display in the entrance area of the Countway Library, extending in a modern medium the library's collection of distinguished eighteenth and nineteenth century portrait paintings. But an added dimension of this gift is that the same originals have been reproduced in portfolio form in a signed, limited edition of 590 — each of which can be acquired by a gift of $500 or more to the Boston Medical Library. The twelve "Healers of Our Age" celebrated in Portfolio Number One are: Walter Clement Alvarez, Charles Herbert Best, Alfred Blalock, William Boyd, Thomas Stephen Cullen, Albert Einstein, Sir Alexander Fleming, Carl Gustav Jung, Helen Keller, Albert Schweitzer, George Hoyt Whipple, and Paul Dudley White '11. Accompanying each portrait is a brief biography, a quotation illustrative of the "healer's" personal philosophy, and a vignette by Mr. Karsh of his encounter with the subject. Mr. Karsh will hand sign each portfolio, and will also inscribe it personally to the recipient, if so desired.

The proceeds from the portfolios will be used by the Oliver Wendell Holmes Endowment to help preserve and enhance the Boston Medical Library's wealth of rare books, historical volumes, and invaluable prints and paintings, and make them more accessible to the hundreds of thousands of people served by the Countway each year.

(continued on p. 6)

An outgrowth of this initial project is a second portfolio already being prepared, of which seven of the twelve portraits are also on exhibit: Henry Knowles Beecher '32, George W. Corner, Robert Debre, Rene Dubos, John F. Enders, Francis D. Moore '39, and Helen Brooke Taussig. The other five are still under consideration by the portfolio selection committee, which consists of Mark Altschule '32, Dwight E. Harken '36, Richard Warren '34, Richard Wolfe, rare books librarian at the Countway, and Leroy D. Vandam, M.D., professor of anesthesia at HMS and anesthesiologist-in-chief at the Peter Bent Brigham Hospital. It is hoped that Portfolio Number Two will be available to loyal supporters of the Boston Medical Library in December of 1976.

The Karsh portrait of Albert Schweitzer

Ebert outlines position on legislation

Dean Robert H. Ebert testified on October 30 before the Senate Labor Subcommittee on Health chaired by Senator Edward M. Kennedy. The Dean addressed his remarks to those provisions of proposed health education manpower legislation which he considered to be of particular importance.

Increased enrollment. Dr. Ebert voiced his support of increased medical school enrollment, stating that it is difficult to justify the present heavy reliance on foreign medical graduates (who comprise about forty per cent of newly licensed physicians each year) when many well-qualified American students are denied admission to medical schools because there are too few places. He added that schools that could demonstrate that further expansion would create hardship for students and faculty might be provided with alternatives, such as initiating or expanding programs for physician assistants and nurse practitioners, in order to qualify for capitation. The Dean also urged that legislation be written to emphasize increased output rather than intake, so that a school could increase its enrollment during the clinical years by admitting American students who had completed their preclinical studies in foreign medical schools.

Required service in underserved areas. "I support the concept of a National Health Service Corps and the principle of national service in return for scholarship support," stated Dr. Ebert. He cautioned, however, that this is "only a short-term solution," and that a more permanent adjustment of the maldistribution of health services could be provided for "by requiring that National Health Service Corps physicians in underserved areas would have formal relationships with nearby community hospitals and regional medical centers." Expressing agreement with the proposed goal that fifty per cent of medical graduates serve in underserved areas, the Dean warned against arriving at this percentage too rapidly. The ultimate goal of permanent recruitment of physicians to these areas would, he said, be best served by careful planning to insure that NHSC physicians have constructive experiences.

The concept of one year of service for each year of scholarship support was also approved by Dr. Ebert, who added that service should in no case be for less than two years, and that "there should be a buy-out provision in lieu of service and I agree that this should be twice the amount of assistance received plus compound interest at market rates dating back to the first year of scholarship support." In the event that there are too few volunteers for national health service scholarships to meet the recommended quota, Dr. Ebert suggested that the remaining positions be filled by a national lottery administered by HEW or by the Association of American Medical Colleges.

Residency positions in primary care. "There needs to be a better distribution between those physicians providing primary care and those providing specialty services," the Dean asserted. "You will notice that I have stated the problem in somewhat different terms than those generally used, and I do so because the issue is not simply how physicians are trained but the organizational framework in which they practice as well." He expressed agreement with the concept that fifty per cent of the approved residencies in this country should be in primary care — provided that primary care training is defined to include: the residencies in family practice, the first three years of internal medicine residencies, the first two years of general pediatric residencies, and the first three years of obstetrical training. As a means of redistributing residencies among the specialties, Dr. Ebert favored placing an overall ceiling on the number of approved residencies with quotas for each of the specialties — this method, he said, "would take into account the different capabilities of the nation's medical schools." If the committee should choose instead to pursue redistribution of residencies indirectly, by requiring each medical school to meet a fifty per cent quota in primary care in order to qualify for capitation, the Dean suggested two exceptions. 1) Those few medical schools having large numbers of residents in affiliated programs might be permitted to comply by maintaining a minimum of 220 residencies in primary care, since complying with the fifty per cent requirement would necessitate discontinuing existing programs which "represent a national asset." (2) Those few medical schools having very large and high quality programs in particular specialty areas might be permitted, at the discretion of the Secretary of HEW, to meet a fifty per cent quota calculated in exclusion of these special programs.

Foreign medical graduates. The Dean recommended a ceiling on residency positions "so that an excess of residencies is not used as an excuse to recruit foreign medical graduates. I

would favor the approval of first year residencies equal to 110 per cent of the number of graduates of American medical schools and suggest that subsequent years of training be controlled by a similar formula." He added that an ongoing mechanism must be developed for allocating residencies in the various specialties on the basis of national need.

Other provisions. Dr. Ebert concluded his testimony with a list of other provisions he would support as part of health manpower legislation:

- "Special scholarships for the disadvantaged for preadmission assistance and scholarship support the first year.
- "An identifiable administrative unit in primary care and/or family medicine, provided that there is flexibility in how each medical school implements this requirement.
- "The recommendation that foreign medical graduates should meet precisely the same examination requirements as American graduates before assuming patient care responsibilities and that further, demonstrated fluency in English be required.
- "Minimum standards for licensure and recertification of physicians.
- "The creation of a national health manpower analysis capability in HEW.
- "Funds for health facilities construction for primary care facilities and construction necessitated by enrollment increases."

In closing, Dr. Ebert pointed out one additional problem whose solution is not, however, within the Subcommittee's purview. "[S]ome means must be found," he said, "for paying residents for time spent in training outside the hospital setting." Unlike most residency training, this time cannot be supported by third-party payors on the basis of service provided to a hospital. "This poses a serious problem," Dr. Ebert stated, "for medical schools that wish to expand the ambulatory medical experience for primary care residents."

We Won't Leave You

Edward Mason, M.D., film producer/director for fifteen years and assistant clinical professor of psychiatry at HMS, took honors at November's Chicago International Film Festival for two documentaries — one of them made at the Massachusetts General Hospital.

Dr. Mason's film *We Won't Leave You*, showing the involvement of parents during a young child's hospitalization for an operation in the MGH's special one-day surgical unit, won the Festival's second highest prize in the health, medicine and safety category. The recipient of the silver plaque in the performing arts category was another Mason film, *Gee, Officer Krupke,* featuring the Harvard Dramatic Club in preparation and rehearsal for its 1973 performance of *West Side Story*.

Psychiatrist/filmmaker Mason's dual areas of expertise complement one another in his work as director of the mental health training film program in HMS's Laboratory of Community Psychiatry. An earlier film of his, *Boys in Conflict,* was a first prize winner at New York's American Film Festival.

Harvard programs for health professionals

Executives in health and health-related organizations will have an opportunity to expand their skills and knowledge in two Harvard programs planned for this spring and early summer.

An Executive Program in Health Policy Planning and Regulation will be held at the Harvard School of Public Health, March 14 through April 9. Designed to develop both analytical skills and substantive knowledge of the health care system, the program will emphasize the political economy of the health system and the use of statistical data, decision theory, cost-benefit analysis, and organizational analysis. Among the problems to be covered are quality of care regulation, Certificate of Need procedures, mechanisms for controlling hospital costs/prices, manpower planning,

Two stills from Dr. Mason's film, We Won't Leave You.

enforcement and inspection techniques, legal constraints and initiatives, and the impact of community and other political pressures on the regulatory process. The program is intended primarily for health professionals holding senior positions in such bodies as comprehensive health planning agencies and health systems agencies, state health departments, Medicaid programs, professional standards review organizations, and rate setting bodies; however, individuals from appropriate federal agencies, state legislative committees, private companies, and health care institutions will also be admitted. Although the closing date for applications was January 15, some places may still be available, and it is not too soon to apply for next year's session. Inquiries should be addressed to: Administrative Director for Regulation Programs, Executive Programs in Health Policy and Management, Harvard School of Public Health, 677 Huntington Avenue, Boston, Massachusetts 02115; (617) 734-3300 extension 2601.

Still open to applications until March 15 is the 1976 Program for Health Systems Management, sponsored collaboratively by the Harvard graduate schools of business, medicine, and public health, to be held June 20 through July 30 at the Harvard Business School. Faculty members from all three schools will teach courses including financial management, marketing management, control, health economics, legal issues, organization issues, health services, operations management, labor relations, and institutional policy and strategy. The program is designed for experienced top-level executives in voluntary, public, and investor-owned hospitals; clinics, health maintenance organizations, government agencies, educational institutions, fiscal intermediaries, suppliers, large employers, unions, and professional associations. Applicants, who must be sponsored by their employer organizations, should address their inquiries to: Assistant Director for Management Programs, Executive Programs in Health Policy and Management, Harvard School of Public Health.

Seeley G. Mudd Lab: new space for research

The Seeley G. Mudd Laboratory, a seven level, 96,000 square foot structure, is rising on the site of a former parking lot in the Medical Area. When it is completed — hopefully by next winter — the laboratory will house research efforts primarily, though not exclusively, in the field of pharmacology.

Working there will be researchers from institutions including HMS, the Boston Hospital for Women, the Peter Bent Brigham Hospital, and the Robert B. Brigham Hospital. At each floor level, the Mudd Laboratory will be joined with the Laboratory of Human Reproduction and Reproductive Biology.

Space allocations have been announced as follows. The basement will consist primarily of animal facilities, but will also include an electron microscopy suite, a workshop, and a computer facility for enzyme chemistry. First floor space will be occupied by Bert L. Vallee, M.D., the Paul C. Cabot Professor of Biological Chemistry, and the enzyme chemistry staff working under him. Members of the Laboratory of Human Reproduction and Reproductive Biology will utilize the second floor. On the third and fourth floors will be laboratories of pharmacology under the direction of Irving H. Goldberg, M.D., Ph.D., professor of medicine and the Gustavus Adolphus Pfeiffer Professor of Pharmacology, while the fifth and sixth floors will be reserved for staff from the Robert B. Brigham Hospital and for studies relating to immunological research.

PROMOTIONS

Professor

John L. Bethune: radiology (biochemistry)
Henning Pontoppidan: anesthesia at the Massachusetts General Hospital
Chiu-Chen Wang: radiation therapy at the MGH

Associate Professor

Thornton Brown: orthopedic surgery at the MGH
Edwin H. Cassem: psychiatry at the MGH
I. Leon Dogon: operative dentistry at the School of Dental Medicine
Ann M. Dvorak: pathology at the MGH
William Grossman: medicine at the Peter Bent Brigham Hospital
George A. Jacoby, Jr.: medicine at the MGH
Rita M. Kelley: medicine at the MGH
J. Drennan Lowell '46: orthopedic surgery at the PBBH
Peter R. Maroko: medicine at the PBBH

William M. McCormack: medicine at the Channing Laboratories
Martin C. Mihm, Jr.: pathology at the MGH
John A. Parrish: dermatology at the MGH
Thomas D. Pollard: anatomy
Heinz G. Remold: medicine (biochemistry)
Edward S. Reynolds: pathology at the PBBH
Robert C. Rustigan: microbiology at the School of Dental Medicine
John F. Ryan: anesthesia at the MGH
Milton M. Weiser: medicine
Gordon H. Williams '63: medicine at the PBBH
Barbara E. Wright: microbiology and molecular genetics

Associate Clinical Professor

Edward M. Daniels: psychiatry
Walter S. Kerr, Jr.: surgery
David C. Lewis: medicine
Chiu-an Wang '43B: surgery
Francis G. Wolfort: surgery

Senior Research Associate

Ezio Merler: pediatrics (immunology)

Assistant Professor

Robert H. Ackerman: radiology at the MGH
Richard A. Baker: radiology at the PBBH
William P. Beetham, Jr.: medicine at the New England Deaconess Hospital
Myron L. Belfer '65: psychiatry at the Children's Hospital Medical Center
Atul K. Bhan: pathology at the MGH
Bruce M. Camitta: pediatrics at the CHMC
Robert W. Carey '59: medicine at the MGH
Robert B. Colvin: pathology at the MGH
Eliezar A. Dawidowicz: biophysics
Marc A. Dichter: neurology
Edwin G. Fischer: surgery at the PBBH and at the CHMC
Warren E. Foote: psychology in the department of psychiatry
Eric T. Fossel: biophysics
Peter V. Hauschka: oral biology
Barry E. Hopkins: medicine
Joel M. Kaufman: surgery
Sheldon D. Kaufman: medicine at the MGH
Ajit Kumar: microbiology and molecular genetics in the department of surgery
Paul B. Lesser: medicine at the Cambridge Hospital
Simon D. LeVay: neurobiology
Myron J. Levin: medicine at the BIH
Melvin D. Levine '66: pediatrics at the CHMC
Richard H. Masland: physiology in the department of surgery
Barbara J. McNeil '66: radiology (nuclear medicine) at the PBBH
Anne Nicholson: medicine
James E. Pennington: medicine at the PBBH
Joel M. Rappeport: medicine at the PBBH
Aldo A. Rossini: medicine at the PBBH
Harold W. Rubin: obstetrics and gynecology at the BIH
Robert M. Sade: surgery at the CHMC
Paul S. Schnitman: prosthetic dentistry at the School of Dental Medicine
James A. Schnur '65: radiology at the PBBH
Ralph K. Schwitzgebel: psychology in the department of psychiatry at the MMHC
W. Davies Sohier, Jr. '46: medicine at the MGH
Nicholas A. Soter: dermatology
James O. Taylor: medicine at the Channing Laboratories
I. David Todres: anesthesia (pediatrics) at the MGH
John B. Watkins: pediatrics
Warren M. Zapol: anesthesia at the MGH

Assistant Clinical Professor

Jane V. Anderson: psychiatry
Thomas C. Cochran, Jr.: surgery
Richard H. Ferraro: dental ecology
Bruce W. Fischberg: psychiatry
Donald P. Goldstein: obstetrics and gynecology
Miguel A. Leibovich: psychiatry
Milton Mazer: psychiatry
William P. Rogers, Jr.: surgery
Joae G. Selzer: psychiatry
Noah I. Zager: periodontology

Principal Associate

Miguel F. Refojo: ophthalmology (biochemistry)
Elizabeth Taber-Pierce: anatomy

APPOINTMENTS

Professor

Calvin L. Rumbaugh: radiology at the PBBH and at the Beth Israel Hospital
Edmund J. Yunis: pathology at the Sidney Farber Cancer Center

Associate Professor

Ellen W. Jones: community health in the department of preventive and social medicine

Assistant Professor

Michael B. Berman: ophthalmology (biochemistry)
Peter M. Blumberg: pharmacology
Geoffrey M. Cooper: pathology
Harry P. Ehrlich: pathology
Michael C. Fishbein: pathology at the PBBH
Michael M. Gottesman '70: anatomy
William A. Haseltine: pathology
Roger D. Kornberg: biological chemistry
Ching C. Ling: radiation therapy (radiation biophysics)
Eva J. Neer: medicine (biochemistry)
Charles E. Riva: ophthalmology (biophysics)
Lester Silberman: obstetrics and gynecology at the BIH
Thomas A. Sos '68: radiology at the PBBH
Richard Zigmond: pharmacology

Assistant Clinical Professor

Jean B. Miller: psychiatry

"The Zeitgeist was ripe..."

by Raymond G. Babineau '63

In the spring of 1974 I found myself having volunteered to teach an introductory course in human sexuality to first year medical students at the University of Rochester. After four years of teaching first and third year medical students, I felt there was a growing need for this type of instruction, believed the *Zeitgeist* was ripe (if not overripe), and saw an irony that this medical school, from which Dr. William Masters was graduated in 1943, was lagging behind other schools in this regard. An additional irony was that college undergraduates at the University of Rochester had available to them an excellent course in sexuality, and were being told that for complicated aspects of sexual functioning they could turn to physicians for help and guidance, whereas in fact at the medical school, student physicians were learning relatively little of direct relevance in this area.

My volunteering was met with a rapid, positive response. A senior colleague, Dr. Otto Thaler, generously sponsored this "mini course" under the umbrella of the first year psychiatry program and performed the miraculous task of extracting from a curriculum committee twelve classroom hours for the fall semester of 1974. For me, easy sailing so far. The four months which followed were something else again. In addition to the work and planning for the course, I found myself personally involved and buffeted about by reactions which surprised me by their intensity and diversity. At first I assumed these reactions were idiosyncratic, but in retrospect I have concluded that although my personal signature was on many of them, some of these experiences might be encountered by any medical educator facing the same task.

Deciding the *formal* structure of the course was not difficult. Curricular efforts at other medical schools (especially the University of Minnesota), SIECUS Publications, and other sources of guidance led me to devise the following format. There would be six two-hour sessions, each divided in this manner:

30-40 minutes of lecture
20-30 minutes films*
60 minutes small group discussions

The lectures and previously distributed reading materials would be aimed at cognition and content, as well as attitudinal assessment and change. The use of eight sexually explicit films seemed critical in avoiding one potential pitfall of such a course — that it might become a detached intellectualized exercise — and would help to guarantee some impact and involvement on the part of the viewer. The small groups had ten students each, led by the same faculty member already known to them as their small group leader for the Psychiatry I course. The topic format for the six sessions was:

- Sexuality and the physician
- Heterosexual functioning
- Masturbation
- Homosexuality and other variants
- Heterosexual function and dysfunction
- Sexuality and the elderly, the ill and handicapped, the retarded.

My task was made easier because many of the psychodynamic aspects of sexual functioning, as well as a psychosexual developmental perspective, were already being taught well in the psychiatry course.

In preparing the lectures, I found experiences from HMS (1959-63) coming vividly to mind. As first year students, we had had a presentation by a renowned cardiologist who discussed the pathophysiology, clinical manifestations, and clinical management of the patient with angina. After the lecture a small group of students approached him with additional questions. One took the initiative and asked if sexual activity was a problem for patients with angina. The lecturer blushed and said, yes, this was an important aspect, but he had not felt it prudent to discuss it before the entire class! A powerful message had been transmitted to us without our being explicitly aware of it — that the sexual aspect of a patient's functioning was not a valid, sanctioned aspect of a physician's interest and concern.

The HMS years passed with little or no information about contraception, sterilization, abortion, the sexual variants, the sexual consequences of various forms of surgery or pharmacotherapy, or the possibilities of a sexual life in those who are ill or disabled. In our third year, a gynecology lecture was scheduled to include some information on orgasm. Class attendance was higher than usual that day, but what we heard were a few vague remarks about orgasm being "frequently overrated," and that women "should not expect a Fourth of July explosion." That was about it. We left vaguely disappointed, largely unaware of how our education was being limited by Massachusetts politics, lingering Victorian taboos, and ignorance of some basic facts about human sexual functioning which were at that time being quietly gathered in St. Louis by Masters and Johnson and being published in relatively lesser known journals (such as *The Western Journal of Surgery*). In preparing the lectures, I gradually realized that part of my own personal "agenda" was to repair for today's medical students some of the shortcomings of the education I had received as a medical student and as a psychiatric resident. (The astute reader will have by this time guessed that I was not only reprimanding HMS for an insufficient sexual education, but more remotely, my parents as well. So it goes.)

Dr. Babineau is chief of the mental health section, University Health Service, University of Rochester, and assistant professor of psychiatry at the University of Rochester School of Medicine. This year he is again involved in teaching the introductory course in human sexuality there.

* Rental films available from such sources as Multimedia Resource Center, San Francisco and Ed Coa Productions, Englewood, New Jersey.

The anxieties began, sometimes felt by myself, sometimes expressed by concerned colleagues and administrators. Would there be casualties to the course? That is, would students be made anxious and psychologically troubled by the material and, in particular, by the explicit films? As chief of the mental health section of the health service, I felt that I would be in a position to see myself, or to hear from colleagues, about adverse reactions. None were detected. In confidential questionnaire responses after the course was ended, none of the respondents found it personally offensive. Some students reported experiencing anxiety, but in a constructive way. Here is one such response: "I was somewhat 'repulsed' while watching the film of male homosexuality. Intellectually I thought I had a liberal tolerance and understanding for homosexual behavior — but emotionally I found I did not. Talking about the film and thinking about my feelings has helped me to bring intellectual and emotional attitudes more in line." A positive effect noted in the months after the course was that three medical student couples came to the health service for help with long-standing sexual difficulties (premature ejaculation, secondary impotence, orgasmic inhibition). They were third and fourth year students but had heard from first year colleagues that help was now available for such problems.

More concerns. Should the course be required for all students as a necessary part of their medical education? Would some find it morally offensive? Nothing was said to the students about its being mandatory but attendance was close to one hundred per cent of the first year class. One student stayed away from the first presentation because of moral doubts until a trusted clergyman could be consulted. After hearing that the clergyman wished he himself had more information and expertise of this sort with which to help distressed individuals and couples, the student attended all further sessions.

As the time approached for the course to begin, my personal doubts increased. Had I yielded to an unnecessary fad in medical education? What right did I have to claim special expertise in these matters? What if the modern liberated student was so sophisticated about sexual matters that my approach seemed elementary, redundant, or excessively cautious? I gradually realized that these reactions were irrational. My professional background was adequate and relevant. The personal experience of fifteen years of a gratifying marriage and becoming a father to three children was also relevant and helpful — I would not have been ready

to teach the course much earlier! The basis for my anxieties lay in the taboos about sexuality, still to be struggled with culturally, in the medical profession, and within my own mind.

My own emotional responses were often useful signposts. My wife, as helpful as she has always been, went over the lectures and previewed the films with me, with an overall positive effect for both of us. At one point, however, on the evening prior to giving a lecture which had given me particular difficulty in preparing, I experienced some transient sexual dysfunction. As I drove to the medical school the following morning, I experienced a moment of self-reproach. "Think of what happened last night. Doesn't that disqualify you as a lecturer in human sexuality?" I then realized that the opposite was true. A point I was trying to emphasize to the students was that to be human was to be vulnerable, in sexual matters as well as in all others, and that such vulnerability did not necessarily imply defect or pathology, but most often anxiety or some other vicissitude of our complex feeling states. So I lectured, simply human, probably with particular effectiveness that day.

Overall, the course went well, with enthusiastic response from the outset. The initial bravado of some students — "who needs sex education at our age" — quickly dissolved in response to either the lecture content, the films, or the small group discussions. The following two comments were typical of replies on the evaluation questionnaire:

"The course made the point that concern with sex as a physician is not limited to psychiatrists or sex specialists (whoever they are) but that many practitioners — internal medicine, cardiologists, ob/gyn, and potentially almost any physician — at some point — can focus on sexual matters/problems with patients. The course emphasized that the physician has an obligation not to mess up the patient's sex life through acts of commission or omission."

"At first I was disgruntled with films dealing with normal intercourse because I felt everyone in my class was liberated and already knew everything about sex that was necessary. After talking in our small group, I realized that not everyone had experienced sex and that there was considerable misinformation. Having realized this, I feel I will be more tolerant of my patients if they express ignorance about certain aspects of sex and I will make fewer assumptions about where my own colleagues 'are at.' I also realize that my own sexual experiences have been contained within certain channels and have had my views broadened as to the spectrum of sexual behaviors."

Individual student reactions expressed in small group discussions often became focal points for clarifying complex attitudes. For example, several students "objected" to one of the films that showed in intercourse a man who had a lump (presumably a small lipoma) on his buttock. In discussing this, it became clear that some students had a kind of "Playboy syndrome" about sexual activity — namely, that it is something appropriate for only the young, the unblemished, or the superbly attractive. Other students drew *reassurance* from the physical imperfections, or evidence of maladroitness of the film participants — it was as though these imperfections or fallibilities made them as individual viewers less personally competitive, more reassured that sexuality was not always (or even often) a matter of perfect bodies, of perfect timing, of perfect relationships. Another student commented: "These films are great for us to watch but aren't they . . . rather depressing for our instructors?" When asked to explain further, he said that since he estimated that most of the small group instructors were "at least in their 30's or 40's" their advanced age excluded them, in his opinion, from the pleasures of sex. Comments such as these helped give greater impact to the lecture and reading material aimed at breaking down the resistance and biases against thinking of the existence, validity, and potential vitality of sexuality throughout life. Regrettably, no film was available of an elderly couple in sexual activity, but when I asked from the lecture podium if students had ever imagined their parents in intercourse or masturbating, it produced a silence of memorable depth and duration and a flurry of discussion later in the small groups.

After viewing a film of a woman masturbating, students were asked for their fantasies of what this woman might actually be like as a person. Several students indicated that they imagined her as "terribly lonely, possibly a schizophrenic living in a garret room." Such reactions helped to make vivid the prohibitions about masturbation and lingering notions that it is a deviant activity, potentially linked to mental illness and social isolation.

The course ended with a set of films which seemed to have the most impact of all. The first film was a discussion group of men and women with spinal cord injuries, recounting their experiences of having had their sexual potential ignored or denied by the medical profession, and their intense need to be alive in a sexual sense as well as in other ways. The companion film showed one of the couples from the same filmed discussion group now in the privacy of a bedroom, making accommodations in their sexual activity to the difficulties posed by the partial paraplegia in the male, but conveying a sense that with ingenuity, encouragement, and a good relationship, sexual gratification and self-validation were indeed possible for this loving couple.

Where to go now? Despite the initial anxieties, an introductory course is the easiest to give. A more thoroughgoing approach to the teaching of sexuality is available in the second year psychiatry course. Our task at this medical school now is to extend teaching and learning opportunities in the clinical years and to insure, for example, that all students are encouraged and supervised in the taking of a complete medical history, one which includes relevant sexual data gathered with as much sensitivity and competence as other data which the physician elicits. On an elective basis, we are looking for ways to offer to students and house officers substantive teaching and clinical experience in the evaluation and treatment of sexual dysfunction.

The fad will not disappear, although new controversies and complexities will appear. Medicine has legitimate claim to interest in sexual functioning as one important aspect of the total psychobiologic organism. More simply, sexual health is a part of being fully human, and student physicians need this emphasis woven into their developing approach to the patient and into their developing professional identities.

Beyond the pale no longer

by Carol C. Nadelson, M.D.

The medical student or house officer is often portrayed by the media as the suave, sexually sophisticated Dr. Kildare. In reality, sexuality for many is full of uncertainties about both personal adequacy and professional competence. Frequently students and physicians are unaware that their peers share the same feelings and anxieties, because they have never had the opportunity to communicate with them about these issues.

The sexual anxiety of medical professionals can present itself in a variety of ways.[1] The student or physician may seem embarrassed or inarticulate, or may simply avoid the subject. This behavior can lead to increased patient shame and discomfort. Treatment of the patient is sometimes brusque, tactless, or even provocative; thus rapport between patient and physician may not be established. Humor can be used defensively, especially in groups (e.g. lecture halls or seminars) where feigned comfort or nonchalance may mask anxiety. Another mechanism for coping is by over-identifying with the patient. The resulting diminished objectivity may produce an answer for the physician's, but not the patient's, need.

Perhaps the kind of training and the personality styles desirable for the "good" medical student mitigate against flexibility and openness; and the control of gratification required for the "good" doctor may make it difficult to ask "charged" questions or explore areas which are too stimulating.

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The myth of physician omniscience is also a special burden. It may prevent inquiry or exploration either because the physician feels that he or she should know all or is fearful of betraying ignorance. If all learning is safely relegated to the margins of the printed page, then it is possible to encompass and control that information only, and to dismiss other input as soft or nonrelevant, thus preventing one's deficiencies from being revealed. In practice, the physician's own prejudices have a direct bearing on the efficacy of the clinical dialogue.

The lack of specific knowledge coupled with the burden of interfering attitudes makes it difficult for physicians to deal with the sexual problems brought to them by patients, or to take an actively preventive role. Upon entering medical school, students share the same ideas, information, and anxieties with other people who have similar educational backgrounds.[2,3] Once in medical school, students have generally been taught about human sexuality while studying anatomy, physiology, and biochemistry, or as a part of the disciplines related to reproductive functioning. Much of this information does not directly relate to the kinds of complex, multi-dimensional problems faced by physicians in practice.[2]

Sex and the Physician

Burnap and Golden have reported on the types of sexual disorders seen by a group of family physicians, internists, obstetrician-gynecologists, urologists, and general surgeons.[4] They randomly selected this group from 110 physicians practicing in a California community representing a wide variation in socioeconomic, ethnic, and racial groups.

The authors point out that the types of problems least often reported were those that were most often included in medical school courses, while the most frequently appearing problems were largely ignored. In addition, the variability in the reported incidence of sexual problems encountered by these same physicians appeared to be related more to the comfort of the physician than to the incidence of a particular problem in the population. Physicians who routinely obtained a sexual history, and were able to discuss sexual concerns with their patients, reported a higher incidence of sexual problems in their practice than those who failed to ask about sexual adjustment. The overwhelming majority of the physicians surveyed felt that their medical school preparation for assessing and treating patients with sexual problems had been inadequate.

Ignorance and anxiety are frequently converted into questions about the relevance or validity of including courses on the diagnosis and treatment of sexual disorders in programs designed to train general physicians. It is important to note that patients with marital and sexual problems go to psychiatrists last, not first; and that sexual problems, while not life-threatening, do cause significant discomfort.[1] This distress can be endured by the patient, but the physician must be aware that many sexual disorders are treatable with reasonable success as are other uncomfortable medical disorders like "asthma, hemorrhoids or Tinea infections."[4]

Types of sexual problems defined and ranked according to frequency

The problem as stated to the physician:	Estimated cases seen per year by sixty physicians:
1. Lack of orgasm during intercourse	1,917
2. Frigidity, or lack of desire for intercourse	1,830
3. Frequency of intercourse, or concern of the patient over how often intercourse occurs	1,146
4. General sex information, no specific problem	1,438
5. Impotence, or lack of erection during intercourse	1,335
6. Dyspareunia, or painful intercourse	1,212
7. Lack of affection in intercourse, whether or not orgasm occurs	1,016
8. Premarital counseling	648
9. Extramarital intercourse, including premarital	633
10. Premature ejaculation	571
11. Sex education of children, including the parent who asks for advice	520
12. Lack of satisfaction with intercourse, whether or not orgasm occurs	419
13. Sexual problems with disease or surgery, such as a woman contemplating hysterectomy	414
14. Sexual problems related to the menopause	410
15. Homosexuality (presented to the physician as a problem)	85
16. Peversions*, all types (presented to the physician as a problem), except those given in No. 15 and in No. 17 through No. 20	35
17. Masturbation	32
18. Nymphomania*, or excessive desire for intercourse by the female	16
19. Incest, or sex relations with other family members	5
20. Satyriasis*, or excessive desire for intercourse by the male	5

* These are the words used by the authors, not further defined in the article.

Lief warns against the relegation of sex education to an accidental encounter during a clerkship, or to the vicissitudes of timing and circumstance.[2] Now almost all medical schools have included courses on human sexuality in their curricula. This is in sharp contrast to the prevailing norm in 1960, when there were only three medical schools with such courses.

Lief has pioneered in documenting the need for study in this area.[5] Over the past decade he has collected data from a Sexual Knowledge and Attitudes Test (S.K.A.T.), which has been given to large groups of people, including medical students. He found that attitudes of medical students differ little from those of their non-medical peers except for a tendency toward conservatism.[2] However, he reported certain deficiencies in specific knowledge that are highly pertinent for the physician: for example, about one-third of medical students do not believe that "impotence is almost always a psychogenic disorder;" almost one-half of medical students believe that "one of the immediate results of castration in the adult male is impotence;" one-third of medical students do not believe that "twenty-five per cent of men over the age of seventy have an active sexual life;" and fifteen per cent of medical students still believe that "certain conditions of mental and emotional instability are demonstrably caused by masturbation." (This last is an improvement over Greenbanks' finding in 1959 that fifty per cent of medical students held that belief.[6])

The implications of these gaps in information are far-reaching, and of great concern to those involved in educating future physicians. At Harvard Medical School, prior to the introduction of a course in human sexuality, we attempted to assess students' knowledge and understanding.[7] Initially we selected a large number of items, similar to those used by Lief in his S.K.A.T.[2] We asked a randomly chosen group of medical students, house officers, and faculty to respond to the questions — many of which were not specific enough or too simplistic according to those tested. They did answer most of the questions correctly, so that either they were extremely knowledgeable, or we did not have a sufficiently challenging instrument. Dr. Johanna Shaw and I proceeded to selectively edit and revise, adding categories, varying the types of questions, and including additional attitudinal and demographic data. The questionnaire was once again pilot tested with a larger and more diversified number of groups. We were finally able to evoke both excitement and despair (it revealed serious deficiencies in knowledge), and to stimulate considerable interest and enthusiasm in those tested. The final test was then used to pre- and post-test students in the human sexuality course at Harvard Medical School and the University of Vermont Medical School.

Although the data from the almost 600 people (medical students, physicians, nurses, social workers, psychologists, teachers, secretaries, paraprofessionals, and undergraduates) who have taken the test to date is not yet completely analyzed, there are some important preliminary findings. The freshman and sophomore students at both medical schools reported a fifteen per cent incidence of very limited sexual experience. Of those physicians and students who believe themselves experienced, there was approximately a fifteen per cent incidence of sexual problems reported. In the factual area, only one-half of all of the questions were answered correctly in pre-course tests. Medical students at Harvard and the University of Vermont did appear to have similar information, confirming the studies of Lief and Sheppe and Hain that sexual knowledge is similar to that of peers in other fields and greater than that of undergraduates.[2,3] The types of questions answered incorrectly revealed the persistance of erroneous myths and misinformation in the:

- physiology and psychology of sexual response cycles;
- diagnosis and treatment of sexual dysfunction syndromes;
- phenomenology of incest, and sexual abuse in children;
- psychological sequelae of abortion;
- physiology of conception;
- etiology of infertility; and
- incidence and practice of homosexuality.

Human Sexuality at HMS

In 1970 the course in human sexuality, which evolved from the response to the questionnaire, was finally offered as part of the Harvard Medical School curriculum for the second year class. The impetus came largely from students who worked with several faculty members to plan and implement it (described by Evelyn Waitzkin '50 in July/August 1975 *Alumni Bulletin*).

The course was unique in its multi-disciplinary faculty and small group orientation. People from Planned Parenthood, the Homophile Community Health Center, Zero Population Growth, the Gender Identity Service, and Pregnancy Counseling Service also participated. In addition to the lectures there were group discussions where eight to twelve students met with male and female faculty co-leaders who each had different areas of expertise. The topics considered were sexual anatomy, physiology and psychology, history taking, variations in sexual behavior (heterosexual, homosexual, etc.), and the medical and psychological aspects of sexual dysfunction. Some other areas of human sexuality, for instance pregnancy, fertility, abortion, were included in other sections of the curriculum, so that they were not specifically taken up in lectures, although group discussions did include consideration of these topics.

Each of the groups, in each year, evolved somewhat differently, depending on motivation, timing, instructors, expectations, and the particular dynamics of the group. Consequently, teaching approaches varied from discussions of personal and professional experiences to role playing and clinical presentations. The use of clinical examples in a flexible way appeared to be more effective in facilitating participation and allaying anxiety than either too much of a focus on personal matters or on didactic material. Students who became involved in their groups found the experience stimulating and rewarding. At times they were highly intellectualized, sometimes they were quite open, and occasionally they were defensive, infurated, and even shocked by their peers and instructors. Gradually perspectives and attitudes changed. For some, the course was an intense and personal growth experience; others were barely touched by it. Although opinions about timing, format, or the quality of teaching varied, there was clear agreement about the content and the importance of including such courses in the curriculum.

The New Course*

When the Harvard Medical School curriculum became elective, the course in human sexuality was redesigned. This year it is being given as a block elective in January and June. While theoretically it is possible for students in any year to take the course, it will most likely have a limited enrollment primarily of first year students. With all courses being elective, both faculty and student interest fluctuates for particular courses; and students have conflicts with certain courses which, although elective, are necessary to complete the pre-clinical portion of the curriculum. We chose to set up the human sexuality course as a separate block so as to avoid possible competition with these other longitudinal courses. This also will have the advantage of allowing the material to be presented in a more concentrated manner rather than having it become diffuse and lose continuity over a longer duration.

The four weeks of the course as it is now structured will be organized as a seminar series. A different faculty member has autonomy for deciding how each topic will be presented. It will focus on a different aspect of human sexuality each week: the psychological and physiological aspects of reproduction in the first week; sexual functioning in normal and handicapped people in the second week; sexual variations (homosexuality, transsexuality, etc.) in the third week; and the medical and psychological aspects of sexual dysfunction, the final week. In addition, each student will have a preceptor for one session a week, in order to pursue topics of special interest in greater depth. We hope to continue to have multi-disciplinary coordination and to use the sexuality questionnaire as both a catalyst for student interest and a method for determining our effectiveness as teachers. We also hope to develop field experiences in conjunction with individual preceptors, to give students a better perspective on the kinds of clinical problems faced by the practicing physician.

It is no longer possible for the physician to hide uncertainty by questioning relevance. Sexual function is a part of human functioning and cannot be divorced from the concern of the physician.

* *This article was written while the course was still being planned.*

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Medicine in Zuni...

by Kim J. Masters '72

I came to the Indian Health Service in July 1973, after a straight medical internship at the University of Florida. The daily fare there, as with most university programs, consisted of end stage illnesses and acute decompensations in all the medical subspecialties from cardiology to oncology. From this new assignment I expected an exposure to acute medicine where the chances for recovery were greater. I found much more.

The Zuni Reservation where I practiced is a community of around 6,000, surrounded to the north and east by Navajo peoples. Thus at the outset one is confronted with people of different backgrounds, different cultures, different modes of living, and different economic standards. The Zunis are predominantly a pueblo people and live in a village, Zuni, founded long before Cortez's explorations of Mexico. Most of the houses have running water, gas, electricity, and telephones. The people derive a reasonable income from federal or tribal employment, but most of all from jewelry making. The Ramah Navajos, on the other hand, were chased off their land during the Manifest Destiny wars of the last century and only resettled in the last quarter of the 1800s. They live in hogons — eight sided structures, made of wood and sod, spaced far apart. With few exceptions, there is no access to electricity, running water, or phones. Most Ramahs are sheepherders who have an average family income of $2,500.

It turned out that the most important dividend of my work was the exposure to these different life styles. As a physician, I was essentially the representative of health science to these communities. I continually found myself having to relate the germ theory of disease and its correlates to views of illness based on spiritualism and the concept of disharmony with nature. It is intriguing to be part of a health system where medicine men provide daily care, and in which our PHS hospital might be either the referral source, when traditional methods prove unsatisfactory, or the initial contact, after which the medicine man is consulted. I acquired a lot of respect for both Navajo and Zuni medicine because on several occasions their methods cured patients whom our medical community deemed beyond hope.

Tribal programs in maternal and child health, community health, and alcohol abuse, begun several years ago, have produced a cadre of Zunis and Navajos conversant with both health science and community traditions. They act as liaisons providing health education to their people, and make physicians aware of tribal views. Their involvement may begin with escorting a sick patient to the hospital and two-way translation of the patient's complaints and the physician's proposed diagnosis and treatment. They can make the physician aware not only of local beliefs concerning a particular illness, but also of important details about the patient's family background, home environment, and financial status. With such assistance the physician can learn how best to approach the patient to achieve maximum benefit from available therapies. Finally, the community workers can visit and if need be care for the patient, and then inform the physician about the patient's health.

While I enjoyed being a physician at Zuni, there were several occasions when I wished that I had taken a rotating internship instead of one in internal medicine. The PHS offers a one week crash preceptorship in obstetrics. Since the physician at Zuni may deliver some forty babies each year and there is a thirty-five per cent complication rate from pre-eclampsia and cephalo-pelvic disproportion to placenta previa and placenta accreta, the training was invaluable.

Fortunately, only thirty miles away is the Gallup Indian Hospital, which has specialists in pediatrics, ob/gyn, internal medicine, ENT, orthopedics, psychiatry, general surgery, and ophthalmology. Advice is merely a phone call away and referral rakes forty minutes by car. Thus, the potential for providing excellent medical care is ever present.

After working in Zuni for a year, it occurred to me that this experience would be valuable for medical students. As a total health system, it is unique — from public health nurses and doctors to sanitarians and community health workers — and long-term follow-up of patients and their families could be realized. One could take an old man to Gallup for gallbladder surgery, provide his post-operative care at Zuni, monitor his wife's diabetes, deliver his daughter's child, and care for his grandchildren. The student could then visit the family at home with a community health worker and learn about family and tribal customs. At the same time, having medical students in Zuni would benefit the Zuni and Ramah Navajo peoples, because they would have a chance to screen the students as potential physicians and encourage those whom they liked to return.

Through the kind assistance of Mr. Gene McElyea, training director at the Albuquerque Area Office of the Indian Health Service, and PHS Headquarters in Washington, D.C., $7,000 was obtained to provide travel and meals for twelve students each year (one per month). With Dr. Raymond Neutra and the department of preventive and social medicine at the Harvard Medical School, a community medicine elective was developed. In the fall of 1974, the elective was approved by the curriculum committee, and the first student arrived in January 1975.

Dr. Masters, who spent a year in Zuni, New Mexico, is now a resident in psychiatry at the University of California, San Diego.

The immediate question that I had as a preceptor was "what does one extract from this wealth of material to teach?" The answer is that the elective basically teaches itself. Dr. Bruce Kessler, the unit director for the Indian Health Service, compiled a list of worthwhile experiences, from spending time in clinics, to visiting the tribal councils, to making rounds with the sanitarian. Having thus provided for a diversified exposure to Zuni life, I found myself supervising primarily in direct patient care. This was done not so much through teaching pathophysiology and medical techniques, but rather through explaining customs, supplying background histories of certain families, and interpreting some Navajo and Zuni words.

Of course, I was continually learning from students. David Bor, one recent student at Zuni, helped to clarify the interrelationship between Navajo medicine and our health sciences. He asked a Navajo medicine man who came to be treated for an upper respiratory infection what he would do if a patient came to him with that complaint. Replied the medicine man, "I don't know, I'm not a doctor." A patient does not approach a medicine man saying, "What do I do for my eczema?" Instead, the patient shows the rash on his or her hands to a Navajo specialist, known as a hand trembler, who refers the patient to a medicine man, perhaps many miles away, who specializes in curative ceremonies, called sings, for that particular ailment. The patient then goes to the medicine man and returns with him to the home where the appropriate diagnosis is made (she must have plucked feathers from a boiled chicken when she was pregnant) and the appropriate treatment instituted (making a sand painting and being anointed with several types of crushed corn kernels).

All in all, helping devise this elective and working with the medical students and these two tribes of American Indians was a rewarding experience for me. It increased my awareness of Zuni and Navajo life styles and cultures by obliging me not only to conceptualize what intuitions I learned, but also and most importantly, to learn along with these students more about illness and how it affects the peoples we serve.

. . . a different sort of elective

by Raymond Neutra, M.D., Dr. P.H., and Robert Buxbaum, M.D.

Since January 1975 the department of preventive and social medicine has been offering a community medicine clerkship at the Zuni Indian Pueblo in New Mexico. The clerkship is given in cooperation with the Indian Health Service of the United States Public Health Service, which provides travel and living expenses plus on site supervision by its own physicians. The two-month course has been open to third and fourth year students who have completed their basic clinical rotations. The students spend a community orientation week at Zuni as a prelude to six weeks of clinical responsibilities, and return to Boston for the last week to write up their community medicine project. There are accommodations for twelve students a year, since the trailer-housing provided by the Zuni Tribe makes possible several weeks of overlap.

When Drs. Kim Masters and Bruce Kessler (Columbia P&S '72) first approached the department with a proposal that we set up a clerkship at the Zuni Indian Pueblo, we discussed a clinical experience in which Harvard medical students would have the opportunity of delivery primary care services to Zuni and Navajo families under the supervision of Indian Health Service physicians. We saw this idea as an opportunity to develop students' abilities in common clinical procedures and to develop a sensitivity to cultural differences between physician and patient, which are even more dramatically evident at Zuni than in Boston.

On further thought an additional possibility presented itself — that of seeing health problems from the community perspective; the Indian Health Service Program provides a unique opportunity to do this. A Harvard medical student arriving at the Zuni Hospital will see physicians who have a number of responsibilities different from those of the staff physicians at a Harvard teaching hospital. Through this rotation, the medical student in essence learns the skills and techniques comparable to what the young physician straight out of internship or residency needs to practice medicine there. The physicians in Zuni are given a fixed yearly budget to improve the health of an identified population. They are told that the prime objective is to prepare these people to set their own priorities and eventually to run the health services themselves.

In the interim, the young doctor acts as their advocate in matters of health. A rather unusual data system allows the physician to count the incidence of disease as it occurs in the hospital, in outpatient facilities, and even in peripheral field clinics. From these data it is soon apparent that the common and serious diseases occurring in this population will respond better to preventive than to curative or rehabilitative efforts. Because of a fixed budget, physicians in Zuni start to get interested in costs in a way they had never been while at a teaching hospital where Blue Cross or Medicare seem to provide an inexhaustable flow of money to cover the most expensive of therapeutic and diagnostic procedures.

Dr. Neutra, who designed the clerkship in Zuni, New Mexico, is an assistant professor in the department of preventive and social medicine and in the department of epidemiology at the Harvard School of Public Health. Dr. Buxbaum is an assistant professor in internal medicine and an internist at the Harvard Community Health Plan. Both he and Dr. Neutra worked in the Indian Health Service – Dr. Buxbaum with the Apache in the late 1950s and Dr. Neutra with the Navajo from 1966-1968.

Medical students in Zuni discover that to provide a full range of services the physicians must work with other people of whose existence they may have been only marginally aware — such as the county social worker, who is crucially important in providing support during health crises. The police, school personnel, the owner of the local trading post and unfortunately, the owners of the off-Reservation liquor stores also influence the health of the people. Within the Indian Health Service the sanitarian who monitors the incidence of sylvatic plague, the dentist who refers patients, the pharmacist who has an unsuspected fund of therapeutic know-how, all assume a greater importance. The new doctor stuck out in the middle of the New Mexico desert is dependent on the nurses, nurse's aides, and other paramedical personnel to a much greater degree than had been the case in a large university hospital. The physician's ability to work well with this team has a great impact on the morale of the hospital and indirectly on the quality of health care of his or her patients.

All members of the health team in Zuni find themselves interacting not only with individual patients and their families, but with the community as represented by tribal officials and other community development groups. Physicians discover that the costly medical technologies that they spend so many years learning to implement at a university hospital have relatively little impact when compared to environmental and social factors that work in the community, but they discover that it is within their power to work with the community in making changes in those factors.

The Indian Health Service, then, provides a unique chance to make a community diagnosis in a setting where community therapy is both feasible and expected. It is one of the few situations in which such a wide range of problems can be observed all at once. So far, the Harvard students have done us proud, both in their capacity to learn and in their capacity to make constructive contributions to the community.

"A community diagnosis"

by Leonard B. Nelson '76

Lenny Nelson '76 spent July of 1975 working with the Zunis on their reservation in Zuni, New Mexico. Each medical student who goes to Zuni devises a project to pursue while there. With sixty per cent of all deaths in Zuni related to alcoholism and more then half of these occurring in persons under the age of thirty, Mr. Nelson decided to investigate further this grave problem. In addition to over one hundred home visits, he helped organize a community health center to care for alcoholic patients medically, psychologically, socially, and culturally. Mr. Nelson describes in part the role of medical students within the Zuni society: "Most of the sophisticated medical technology found in the Harvard teaching hospitals cannot be found in Zuni. Many of the common laboratory procedures must be performed by the students and doctors On a typical night on or weekend duty, all x-rays are not only read by the students and doctors, but must be taken by them as well. The student's responsibilities for the care of the patients are usually greater than what they are in a Boston hospital – it is not uncommon to treat up to fifty outpatients a day.

"I quickly learned the limitations of their medical facilities when I accompanied a moribund six month old baby in respiratory distress on a forty-five minute flight to Albuquerque because our hospital was not equipped to handle this emergency adequately. Then there were the acute appendicitis and surgical trauma cases that we often had to drive forty miles over poor roads to a larger medical center for assistance. Zuni is more than just 3,000 miles from Boston; it is also many cultures removed. It is a land where the students and doctors must overcome not only the limited medical facilities, but also the blatant mistrust by Americans who have long been neglected."

There is a legend among the Zunis handed down from many generations that was related to me by the tribal historian, Andrew. It says that the Zunis should be concerned with the white man because with him he brings the brown water that will make all who drink it crazy. After I made an intensive sociological inquiry into the effects of alcoholism among the Zuni people, I understood that the "brown water" had indeed instigated significant changes in Zuni.

When I first arrived in Zuni and observed the number of people afflicted with alcohol related illnesses, including several twenty to twenty-five year old patients dying of cirrhosis, I was stunned. I soon learned that approximately ten per cent, or twice the national average, of the adolescent and adult population are abusive users of alcohol, and that almost every household within the Zuni community is affected by alcoholism. Among Zunis, cirrhosis is the leading cause of death, while ranking fourth for the Indian population nationally and eighth among non-Indians.

Lenny Nelson '76 with two of his Zuni patients

Another exceptional statistic is that the twenty to twenty-nine age group suffers the highest rate of alcoholism, which is twenty years younger than the national average.

The Zunis are an extremely young population with approximately sixty-five per cent under twenty-five years of age. In a study of the mortality statistics by Dr. Robert Vondervagen at Zuni over a fifty-four week period from mid-December 1972 through December 1973, there were fifty-seven deaths. Of the forty-three male deaths, thirty, or seventy per cent, were alcohol related. Thirty-four of the fifty-seven deaths in the Zuni population or sixty per cent of all deaths associated with alcohol occurred between the ages of twenty and twenty-nine. It is apparent that alcohol contributes significantly to the mortality of the young people in Zuni: seven out of sixteen cirrhotics are below the age of thirty years; twelve out of eighteen accidents also involved persons below the age of thirty years. Therefore, nineteen alcohol related deaths out of thirty-four, or fifty-six per cent, were younger than thirty years old.

The purposes for which alcohol can be used are many. The standards of acceptability applied to the manner or pattern of drinking vary according to age, sex, cultural background, social class, and particular circumstances. It is impossible to isolate the attitudes, purposes and standards associated with the use of alcohol in any sociological context from the total structure and history of that social organization. Yet there is no doubt that there has been a significant sociological impact of alcoholism on the Zuni. When viewed in terms of the tragedy, unhappiness, suffering and indeed the waste of life that the illness has brought both its victims and their families, even the most callous observer would be affected.

One of my first home visits was to a Zuni male, Ned, who was left a paraplegic a year ago following an auto accident caused by his being intoxicated. During the two weeks prior to my visit he had fallen out of bed twice while drinking; even after a near fatal alcohol related auto accident, he had continued to drink. When I asked him why he still indulged, he replied, "The doctors told me that my legs are dead but my insides are fine, and that it was all right to continue drinking." He attributed his accident solely to inadequate lighting on the roads. His wife had begun drinking heavily following her husband's accident, and I saw that their children were being neglected.

Maryann was a middle-aged Zuni who came to the emergency room with a two centimeter deep scalp laceration sustained from being kicked in the head by her alcoholic husband. She was in tears as she related her suffering during the past several years due to her husband's alcoholism. Not only had she been physically abused on several occasions, but she was being destroyed by the mental anguish of having to assume the roles of both parents, to shelter her children from their intoxicated father. She had withstood this mental and physical cruelty because, "There are times when my husband is not drinking, and during those times he is a good man and a warm father. I have not left him because I keep believing that soon he will stop drinking."

The old Zuni Hospital

One of the nurses at the Zuni hospital came to see me to seek help for her husband. "I have cried every night for the past eight years," she told me, "because my husband, who is an alcoholic, is slowly killing himself. Every night he awakens in fear, screaming, and every morning he vomits and shakes. I thought that my children would be as disgusted as I am with his drinking, but now my eighteen year old son has started drinking heavily himself. Alcohol has destroyed my marriage and everything I love."

In a Zuni family, having an alcoholic is bound to cause emotional problems no matter how strong the marriage may be. Too often I made home visits only to find an environment filled with sadness, suffering, and loneliness. The children have emotional problems resulting from anxiety over their parents' drinking. Too often they are deprived of that which they need most — a responsible, responsive and predictable parent upon whom they can depend. Assigned to write about alcoholism in Zuni, one high school student responded: "Drinking is a problem in Zuni, yet the Zuni people do not realize it. All they care about is getting drunk. Drinking has changed life in Zuni in a whole lot of ways. There's much more drinking now than there was ten years ago. I remember when there weren't many beer cans lying around in Zuni. Now the place looks like a beer can dump. Don't they care anymore? It looks like the whole village is going crazy. People killing each other, homes broken, families fighting. All this is caused by alcoholism."

Many Zunis believe that while intoxicated they are "possessed" by witches and thus are not responsible for their actions. This is considered by Levy and Kunitz in their book, *Indian Drinking:* "Thus it was that the Indian came to see that changes-for-the-worse were to be expected during drunkenness, for at such times the drinker was temporarily inhabited by an evil supernatural agent. And from this, the Indian reached the entirely reasonable conclusion that since he was thus 'possessed,' his actions when drunk were not his own and he was not responsible for them." Many of the Zunis who believe that they are "possessed" while inebriated will attribute any alcohol related illnesses to their being witched rather than to alcohol itself. Therefore, if they

become ill they will seek the medicine man in Zuni instead of going for medical help at the PHS Hospital.

Zuni has seen vast economic and social changes during recent years, primarily from an expanding market for their silver and turquoise jewelry. An estimated ninety per cent of all Zuni families are involved in jewelry manufacture, and family income has increased rapidly: from $585 per capita in 1969 to $1,200 per capita in 1974. This has provided Zuni families with greater buying power and thus a higher standard of living. But as the jewelry business has flourished over the past ten years, so has the drinking problem. After the typical jewelry producing family acquires its color television and pick-up truck, it has no concept of what to do with the rest of its sudden and sizeable wealth. The life style created by jewelry production is conducive to drinking — individuals sit and work for long hours according to their own timetables.

With the flourishing jewelry business replacing agriculture, hunting, and raising sheep as the primary mode of existence, the Zuni male has lost much financial responsibility within the family. It was not too long ago that the Zuni man was the main breadwinner, working long hours to provide for his family. Now, the jewelry business allows the woman to assume equal if not greater responsibility for supporting the family. Her husband can leave for indefinite periods of time and the woman will continue producing her jewelry with no lack of security. Therefore, the husband sees himself as less valuable because of a less essential role for the family's financial well-being. As a result, alcoholism becomes an escape from the male's inferior social position and is misused as a form of recreation.

Many families of different ethnic groups (whom I have been exposed to as both a medical student and in my personal life) tend to ostracize an alcoholic family member. Such a person is often looked down upon, divorced from many family functions, and becomes isolated, receiving little if any family support or care. However, among the Zuni families, the alcoholic is not usually rejected, although there may be variable persuasion tactics attempted to help ameliorate the drinking problem. Because the Zuni community is closely intertwined, if a family, under extreme circumstances, should reject the alcoholic, he or she can usually find a new home reasonably quickly. Most Zuni families will rarely seek professional help, but usually accept and care for these individuals themselves. Thus, the alcoholic in Zuni is accepted in the immediate or extended family circle and receives minimal encouragement to stop drinking. Many of the negative traits of the alcoholic in Zuni are actually reinforced by well-meaning family members.

There are few established forms of recreation in Zuni. This, combined with the new affluence of the community, has meant that many Zunis resort to alcohol as a form of recreation. They are a very homebound people who rarely leave the reservation to travel, and who have had little exposure to life in other parts of the United States. It seemed to me that many Zunis rationalize their drinking habits by saying, "Everybody drinks and if the Anglos can do it, then we should be allowed to drink as well."

More than half of the alcoholics are heavy beer drinkers. Many of them view beer as a mild alcoholic beverage different from wine or hard liquor. Beer drinkers themselves, as well as their families, will often deny the effects of beer drinking even with prevailing medical, social, and psychological complications of alcoholism.

The Zuni police, many of whom drink themselves, have had a negative impact in dealing with the problem. They have a poorly informed concept of the complexities of alcoholism, as illustrated by this statement from the police commissioner: "The alcoholics are sick people and the only way to deal with them is to put them away in one of the rehab centers in order to do anything for them."

The police often abused alcoholics. On many mornings I would see an intoxicated twenty to twenty-five year old who had been detained by the police since two or three in the morning for disorderly conduct or drunken driving and who, upon arrest, had been brutally assaulted by the police. Many times these people would come to see me at the hospital with lacerations sustained five to six hours earlier, having been imprisoned through the night. By the time they

were seen for treatment, their lacerations had become infected and could not be sutured. Many of these patients deeply hate the police. They indicated that this brutality caused many to drink excessively in rebellion against the police force.

By law the Zuni reservation is not permitted to have liquor on the premises. Considering the serious problem with alcohol related auto accidents, one would expect the police to have a well organized, thorough, and consistent roadblock program to detect and prevent liquor from being smuggled into Zuni. However, their roadblocks were inconsistent, minimal, and thus inadequate. Within a twenty-five minute radius from the reservation there are two bars where many Zunis purchase alcohol — one in Arizona and the other

in New Mexico. Both have been accused of selling alcoholic beverages to Zunis who are under age, perpetuating their alcohol abuse.

There is no coordinated program for dealing successfully with this problem. Although an existing alcoholism program, the PHS, various social services, and religious groups have tried as best they could, the magnitude of alcoholism in Zuni made separate institutional efforts ineffectual. Many of the present and former alcoholics will not seek or accept help from the alcoholism program or from other Zunis because they fear notoriety. For the same reason, efforts to start a chapter of Alcoholics Anonymous have been thwarted.

The treatment and rehabilitation of an alcoholic patient frequently decomposes as soon as he or she leaves the hospital or physician's office. Regardless of how helpful and genuinely therapeutic a regime may be, the patients view the professional time devoted to their improvement as representing only a small fraction of their total lives. Once they return to the community, they find themselves face-to-face with the very real issues of where to go, what to do, and what to expect from the social environment. If "cured" alcoholics are forced to find their way alone, and especially if they must return to the same situation as before, the likelihood is that they will be unable to withstand much stress before resorting to alcohol again.

By the time that many alcoholics are first seen by a physician, many of the stabilizing sociological factors in their lives have been damaged or destroyed. Also the persons affected directly and indirectly by the patient's illness are likely to need help. Thus true remedial treatment requires the combined efforts of many individuals in the total rehabilitation of the patient and the patient's family. This can be accomplished only as a comprehensive team endeavor in which all community resources are mobilized and utilized to their fullest potential.

Realizing the severity of the problem, most of the staff of the alcoholism program, along with a social worker and I, tried to think of ways to increase the care available to the alcoholics and their families. In January 1976 the PHS moved into a newly constructed hospital, relinquishing their present building to the tribe. One mode of improving the total care for the alcoholic would be by converting the former site of the hospital into a comprehensive alcoholic center, which would be an exhaustive undertaking. We proposed this to Governor Laselute who gave us his support; through the tribal council it was agreed to donate the hospital building for our proposed alcoholic health center. Our next step was to begin drafting an extensive proposal for submission to various foundations for financial assistance.

In addition to the current director and several staff members of the present alcoholism program, there will be a social worker and medicine man, all working full time. The part-time staff will consist of a PHS doctor, nurse (RN, LPN and/or nurse's aide), priest, and a Zuni volunteer. The staff will have primary responsibility for the care of both in and outpatients, with each staff member having his or her own patients. There will be daily rounds on all inpatients, so that every staff member will know each patient individually. At bi-weekly case review meetings patients will be discussed among the entire staff. Each staff member will conduct individual therapy with his or her patients, making an effort to develop a therapeutic relationship through a sympathetic attitude, which demonstrates interest and acceptance without explicitly condoning alcoholism. There will be an attempt to provide the patient with a sense of protection, yet encouraging gradual and progressive independence. Once the relationship has acquired a firm foundation and the patient feels secure in it, he or she can be carefully guided toward recognition and acceptance of alcoholic problems and then to greater personal responsibility in dealing with them.

Group therapy with alcoholics often proves much more effective than individual therapy. Perhaps one reason for this is that problems in interpersonal relationships plaguing the alcohol depen-

dent person can frequently be recognized and dealt with more readily in a group situation. However, because the Zunis are reluctant to open up in group situations, group therapy in the new health center will have to be done initially on an experimental basis, often in conjunction with other activities.

When the patient leaves the health center, follow-up care will be a vitally important function of the staff to aid patients in meeting everyday problems and in developing workable methods for coping in the future. This will be a unique feature of the proposed health center compared to the capabilities of the alcoholism center and those in Wyoming and Albuquerque, where there is no provision for follow-up care.

Another unique feature of the health center will be its close association with the new PHS hospital both geographically and through a unified team approach to treating the alcoholic. The PHS physician's participation in the health center will be potentially unlimited. Knowledge of the multifaceted problems associated with alcoholism will certainly place such a physician in a unique position from which to be a guiding force in increasing the center's effectiveness and helping it become a focus for community-wide programs.

There will be basically three types of admission to the health center:

1. When a patient is seen at the new PHS hospital with alcohol related symptomotology serious enough to require hospitalization, the staff of the health center will immediately be notified, and they will then closely follow the patient's stay in the hospital. Once the patient is stable, he or she will be admitted to the health center.

2. When a patient is seen at the PHS hospital with alcohol related symptomotology not serious enough to require hospitalization, the health center staff will still be notified. Together they will discuss with the patient the possibility of admission to the health center for rehabilitation. If the patient voluntarily admits him or herself to the health center, the PHS doctors will continue to follow the case medically.

3. An alcoholic who is not medically ill may be voluntarily admitted to the health center for rehabilitation. On admission, the PHS staff will be notified to facilitate close medical follow-up on the patient. This third type of admission will probably not prevail initially. It is first necessary that the prospective patients be made aware of its benefits.

Because many alcoholics believe that while they are inebriated they are "possessed," they will submit to the medicine man before seeking the help of a medical doctor. Thus another unique feature of the health center will be the presence of a full-time medicine man on the staff who will offer a different perspective to that of the "white man's" medicine.

Part of the rehabilitation process is providing constructive, worthwhile projects. These will include the standard arts and crafts and also vocational training. The opportunity for accomplishment through vocational therapy lets the patient gain feelings of self respect and self reliance. Many alcoholics in the past refused to go to the available rehabilitation centers because during the time spent there they were not able to support their families. Therefore with this in mind, part of the vocational therapy will be the availability of projects that will be able to earn the patient some money — making jewelry, dolls, pottery, etc. These projects can also be oriented towards group and even family participation, all beneficial to the patient's rehabilitation.

One cannot hope to rehabilitate the alcoholic without continuous interplay with the family. The needs of each alcoholic's family may differ. Some will need to be educated about alcoholism; others will need intensive psychological support in recovering from its social

New quarters of the PHS's Zuni Comprehensive Community Health Center

consequences. One of the prime responsibilities of the social worker will be organizing an efficient and productive family service department.

An extensive program organized by the staff members and utilizing all available resource people will be set up to provide:

- professional and in-service training education;
- community and specific public education;
- formal and informal school education; and
- information and referral.

The process of educating different institutions will involve continuous lectures by the professional staff, former alcoholics, and all other available personnel. There will also be small group discussions using audio-visual materials. This will create a positive atmosphere conducive to the development of a network of therapeutic, rehabilitative education, and preventive services.

Remarkable progress has occurred in identifying the metabolic course of alcohol through the body, but much is still unknown. Even fewer studies have assessed the psychological and social treatment methods for alcoholics. Since alcoholism has caused significant morbidity and mortality in Zuni, facilities should also be set up there for research into the biomedical consequences of alcohol. This should be organized in conjunction with other institutions such as IHS, NIH, and NIAAA.

The police too must be educated about the nature of alcoholism. They must be taught that it is a serious illness and that brutality is not a method of treatment. Only after the police possess a deeper understanding, will they then attempt to change their almost inhumane behavior towards alcoholics. Also a better organized and effective road block system must be instituted in Zuni so that the number of fatal auto accidents due to alcohol can be reduced.

Diseases seldom have a single cause, epidemics often do. As the wealth in Zuni has increased, so has the problem of drinking increased proportionately. Whether the jewelry business and its attendant wealth and non-structured life style is the leading cause of an exacerbated drinking problem in Zuni is a matter of debate, but beyond a doubt it is a significant factor. Approximately ninety per cent of Zunis make jewelry, some of them earning $1,000 and $2,000 a week, tax free. It has been proposed by several citizens that a community tax be instituted. As Zunis pay only federal tax, from which the profits of their jewelry business are exempt, a progressive type tax would not present any hardships. The collected tax would benefit the tribe by defraying the construction costs for recreational facilities in Zuni. All money would be allocated in a public fashion.

Alcoholics are treatable patients. Their illness is a chronic disorder with a tendency towards relapse. Therefore alcoholism should be approached in much the same manner as other chronic relapsing medical conditions. The aim of treatment should be viewed more as one of control than of cure. Although abstinence is a primary objective of any program, other considerations may be better guides in evaluating the success of a treatment program. Among these is improved social and occupational adjustment without having to use alcohol as a crutch. A fundamental reason for widespread alcoholism in Zuni, basic to their culture, is the lost financial responsibility of the man. With the present structure of their society, it is hard to imagine how this problem can be resolved.

As I pursued my study in Zuni, I experienced several emotional reactions — a feeling of sympathy in seeing many people suffering because of alcoholism, a feeling of bewilderment because so little was being done for this the leading cause of death, and, finally, a desire to initiate an effective means towards making Zuni a healthier place to live. I only hope that other medical students who go to Zuni will realize that although a unified approach to alcoholism there will invariably run into countless frustrating barriers, with hard work, dedication, and an understanding of the Zuni culture, they will eventually help the Zuni people overcome their obstacles.

Primary care in the field

by George A. Lamb, M.D. and Cheryl Barger

Left: Dr. Gerald Corcoran, family practitioner in Needham and Minerva Campos '79 can walk from his office to see patients at the Briarwood nursing home. Above: at the other end of the street is the Visiting Nurse's Association, one of the community agencies visited by Ms. Campos.

Dr. Ilana Kraus, pediatrician at the Brookside Family Life Center, Kathy Bloomer '79, and their young patient all look intrigued by the sound of his heartbeat.

Dr. Grover Farrish, primary care physician in Hyannis, instructs David Arredondo '79 in using the vitalometer for a multiple breathing test. The fourth preceptor-student pair this January was Robert Funkhouser '48 of Cambridge and Cheryl Warner '79.

Attending to the total health needs of a community or a group of people is a complex responsibility that cannot be fulfilled solely by the provision of even superb clinical care. The patient's environment, family, life style, occupation, socioeconomic status, and health expectations are all issues that influence not only the success of prescribed therapy, but subsequent access to care. Once students begin clinical rotations, they have relatively little opportunity to examine these multi-faceted issues in patient care outside of the tertiary health care facility.

The department of preventive and social medicine, working with the Harvard Medical Alumni Association, has developed a preclinical preceptorship in primary care. The organizing committee included the authors and Drs. Dieter Koch-Weser of the department, William Van Arsdell, and Robert Lawrence '64 of the department of medicine. Langdon Burwell '44, Larry Siedl '61, and Eleanor Shore '55. Preceptors, many of whom were Harvard alumni, were selected with the help of Drs. Burwell and Siedl. Following their initial preceptorship experience, they were all given the option to volunteer themselves again, and several have. The goal of this month-long elective (an option for either January, June, or July) is to provide the first or second year student with more intimate patient contact. Each student is assigned to a physician preceptor and exposed to a practice that serves an identified population. Such field experience hopefully will help the student further refine his or her interests and needs in making a career choice, and if appropriate, to reinforce an interest in primary care as a reasonable alternative. Thus, one model of primary health care will exist to balance, at least partially, the many examples of secondary and tertiary care that will comprise the remainder of the student's medical education.

Dr. Lamb is an associate professor in the department of preventive and social medicine, and the course instructor for the preceptorship in primary care. Ms. Barger taught the section on the economics of medical care and is involved in placing students with appropriate preceptors. She is interested in ambulatory care design and is working towards her MBA in health care management at Boston University's School of Management.

The format for the elective is a three-week field experience preceded and followed by three days of discussions and seminars. The students select preceptors from the list of physicians (compiled by members of the Alumni Council) who volunteered to participate following an invitation from the department — rural, suburban, and urban practitioners involved in pediatrics, internal medicine, general surgery, and family and general practice. The student's choice is based mainly on a description of the preceptor's practice and on the specific types of experience each student seeks. During the three weeks the student is expected to gain a feeling for primary care — its rewards and frustrations — through developing a sensitivity to the preceptor, his or her family, and office personnel.

The initial three-day didactic session introduces some of the issues that the students will be facing: quality and assessment of health care, treatment effectiveness, the economics of health care (the impact of finances on the physician and the patient), the philosophy of primary and preventive medical care, and the impinging political, legislative, and social forces on medical practice. Some of these preparatory seminars were designed to focus on the individual needs and objectives of the students themselves.

Several systematic approaches are suggested to assist the student. One of the required exercises is a series of interviews with patients, some with chronic and some with acute conditions. The student first meets the patient in the preceptor's office and if the patient agrees, the student then arranges for and makes a home visit. This gives the student a more complete overview of the patient's socio-economic status, the social and environmental factors that may have influenced the individual to seek help at that time, the emotional and financial impact of the illness on both patient and family, the degree to which they are satisfied with the care being given, the patient's reaction to use of paramedical personnel, and so forth.

Beyond family visits, the students are asked to complete three to six interviews with community agencies to determine the role and influence of their preceptors in the community, and the resources available and the possibilities each physician has to utilize these resources for improving the health of his or her patients. The students also accompany the preceptor and paramedical personnel during office, hospital, nursing home, and home visits to acquire an understanding of the education, roles, function, and interrelationships of health care professionals. Through the field experience the student can perceive how the organization of the preceptor's practice affects the management of patients, their concerns and needs. Indeed, a number of preceptors felt that the questions asked of them by the students were quite provocative and gave them a creative "outside" perception of their practice that they found helpful.

At the end of the field experience the students return for the final three days of seminars and discussions correlating their experiences and the issues raised to the objectives of the elective. Each student presents the viewpoint of his or her particular perceptor and their ensuing experience. Despite their lack of clinical experience, the students intelligently discussed quality and assessment of care, with awareness of PSRO legislation and the impact this would have, or has had already, on primary care and its cost. Given the importance of and confusion around Medicare and Medicaid, the mechanisms and problems involved in each were discussed with the students.

Ten physicians participated in the June and July 1975 rotation (one student was placed in June, and one July student had two preceptors). Six were located in rural areas — one each in Vermont and New Hampshire, and four on Cape Cod. Four were urban physicians — two each in Boston and in greater suburban Boston.

The suburban preceptors were an internist in a large suburban multi-specialty group and an internist- endocrinologist in a small group practice.

One of the rurally situated preceptors is an internist at the Matthew Thornton Health Plan in New Hampshire — a multi-specialty group practice with eleven physicians, one goal of which is prepayment. A variety of health professionals are employed, including registered nurses, nurse practitioners, and medexes. The student assigned to this preceptor also spent large amounts of time with other physicians and health personnel on the staff, as well as with the Visiting Nurse Association.

There are four solo physicians: one located in Hyannis, a board certified cardiologist, uses registered nurses and medexes; two family practitioners — one in Vermont and one in Woods Hole — both with a registered nurse on their staffs. The other solo physician began a residency in surgery, but became involved in the treatment of patients with drug and alcohol abuse and decided that surgery did not allow him the direct patient contact he wished. Since his switch from a surgery residency to family practice, he has continued to be actively involved in alcohol dependency programs on the Cape, an area with an unusually high alcoholic population.

The final rural preceptor, located in Falmouth, is a board certified internist who has two partners and also uses medexes in his practice. All except the Matthew Thornton Health Plan are fee-for-service.

One of the urban preceptors is a pediatrician at the Brookside Family Life Center, which as a neighborhood health center practice is a unique model for the wide range of health services that can be handled by a team. The other, a cardiologist-internist at a large multispecialty referral center, provided more secondary than primary care, but the student's experience with him raised many issues and questions about the relationship of primary to secondary and tertiary medical care.

The nine medical students (four men, five women) chose this elective for very different reasons. One had previously acted as an "apprentice social worker" to Dr. Robert Lawrence at Cambridge City Hospital. He was interested in a career in primary care and wanted to learn how a physician provides comprehensive health care on a long-term basis, particularly for the "worried well" and those with psychosomatic diseases. Two female students trying to ascertain a better idea of the role of women in primary care selected female preceptors. One, whose father is an internist, felt it was particularly important

for her to see how a woman could combine a medical career and a personal life. Another, the daughter of an urban physician, enrolled because she decided to learn about rural primary care firsthand since that is what she intends to practice. A fifth student, who had "grown up" through an experience in a neighborhood health center environment, wanted to see the alternative experience of private practice. A student having some previous interest in drug dependency problems hoped to discover where the physician can fit in; he matched with the preceptor involved with drug dependency programs on the Cape. One student selected a preceptor near her hometown in Vermont with a possible goal of returning there herself as a primary care practitioner. Another student who was unsure of his career interests nevertheless wanted an early exposure to primary care. The last student, assigned to a suburban preceptor, elected the course — convinced he was going into specialty training or research — to better understand the problems of applying new information and specialty training to the field of primary care. He came away with plans to return in his third or fourth year.

For several of the students, their experiences familiarized them with certain issues in medicine to which they had little or no exposure and in all likelihood would not have until quite late in their training, if then. One female student who read *Immaculate Deception*, a book about the dehumanization of the pregnancy and childbirth experience by institutional medicine, became involved with the women who had or were planning home deliveries, and with the doctors who had agreed to assist. The popularity of this trend ceased to be a women's rights issue in the eyes of the local medical community and instead became a financial and political controversy. The student's involvement in this problem was quite instructive to her as an example of the political, economic, and social implications of change in medical care. It also highlighted some of the inherent discrepancies in goals of physicians and patients. The students as a group were intrigued by the implications of women controlling their own childbirth experiences. It also forced that one student to consider how, as a woman and a future physician, she would react to and deal with such a dilemma.

The student at the Matthew Thornton Health Plan observed politics from another vantage point. She saw the opposition of a relatively conservative community to this organizational model, even though the cadre of traditional physicians was insufficient for the area's population. The physicians at Matthew Thornton Health Plan envisioned prepayment as an important development toward their ultimate goal of becoming a health maintenance organization. The HMOs are few in this country, and seemingly far removed from the usual fee-for-service practice. By the time the student began her preceptorship, community opposition had begun to fade, but professional opposition was still present. She became aware of some of the larger political issues confronting the Plan as a result of its organizational pattern. Many types of paramedical personnel are used, which further alters the type of health care available to the community. Some of the other physicians unaccustomed to a team approach to patient care attacked it as inappropriate. Such political entanglements were a part of medical practice that the student had never known about before, and she expressed concern at the time taken away from patient care to deal with these problems.

One of the students on Cape Cod saw the impact that PSRO legislation was having on that community's physicians. Her preceptor had pointed out that the members of the medical audit boards for the various departments in the hospital were by and large members of those same departments, and were reluctant to criticize their colleagues. This prompted a discussion later among her and the other students about the possibility of professional whitewash. A reverse side of this political question was revealed by the activities of another preceptor, also practicing on the Cape. That individual was an active proponent of implementing PSRO legislation, convinced that local peer review was not only possible but the best method to evaluate the quality of health care.

The student placed with the suburban group of four physicians who practiced in Swampscott, where not all patients had access to primary care, discussed with his preceptor the question of expanding the practice. A large proportion of the population were Medicare and Medicaid patients, and the practice could not handle a proportional number of patients financed by this mechanism. Furthermore, the financial overhead of an additional physician or physicians was estimated to be too high to leave a sufficient profit margin. The student helped in considering the available options for this practice and wrote his required paper on the financial structure of the preceptorship site and its involvement in these issues.

These examples are but a few of the meaningful experiences and discussions generated by the preceptor experience. The evaluation of the elective by faculty, preceptors, and students was generally positive. The major needs were for an appropriate matching of students and preceptors and proper balancing of academic and practice experiences during the three weeks of the preceptorship. The formal pre- and post-course tests demonstrated that both new knowledge and changed attitudes about primary care were outcomes of the elective. However, these are difficult to interpret because of the small number of students. The investigations of Dr. Mark Plovnick of the Sloan School of MIT into the relationship of each student's learning style and career choice were pursued with this group of students, but again the numbers were too small to make any valid conclusions.

Too often education does not help students in making their career decisions nor assist them in gaining exposure to situations that can act as a link between learning medicine in the classroom and practicing it in the community. The hope is that this elective will be such a link.

If anyone is interested in discussing the program or becoming a preceptor, please contact Ms. Barger or Dr. Lamb at 734-3300, extension 2311.

FORUM TONIGHT:

Medicine & Society

by Leona Baumgartner, M.D.

The past seven years have seen the development of a new HMS institution: an evening forum devoted to exploring aspects of the interplay of medicine and society — open to students and faculty from Harvard, Boston University, and Simmons College, and people from the surrounding community. It began officially in the fall of 1967, amid the increasing activism of the 1960s. Schools from Berkeley to Kent State to Columbia were witnessing a variety of expressions of unhappiness, loss of faith, and, even violence "against the establishment."

At Harvard in 1966, Students for a Democratic Society had its largest unit is the country.[1] Harvard SDS moved rapidly to the left in 1967, and student political activity mushroomed during the 1966-67 school year.[2] Anti-war and anti-draft sentiment was on the rise. The visits to Harvard of both Vice President Humphrey and Secretary of Defense Robert McNamara were met with protests — the latter making his escape through tunnels under the school.

Little wonder, then, that there was also a new ferment rising in the medical schools of the country. At HMS, Dean Robert H. Ebert responded by recruiting physicians with broader, less traditional backgrounds and establishing a variety of new acitvities. He agreed that the Medical School should concur with the Cambridge City Manager's request to plan health services for that city, expanding on its loose affiliation with the Cambridge City Hospital. Together, the Medical School and the School of Public Health organized the Center for Community Health and Medical Care.

Dean Ebert appointed me professor of social medicine. Only Dr. Bob Glazer had previously held this title, and he had quite other responsibilities. I had a small office in Building A and so was easily available to the first and second year students. Lunching frequently at Vanderbilt Hall, I found an increasing number wanting to keep up with what was going on in Cambridge, or to learn what was wrong with the health care system, or to find out where they could work with migrant workers or in the "ghetto," as it was incorrectly to be called. Requests for summer jobs outside the laboratory increased, and such jobs were found for many. Dr. Joe Gardella, then dean of students, agreed that those students who had a well formulated hypothesis, a plan to collect and evaluate evidence, and a faculty adviser, could even get some of the precious public health summer fellowships usually given for laboratory work. Since then, each year has seen more extracurricular programs to help meet these students' desires. During the spring of 1967 a group of six students worked on an informal health survey for one of the health groups in Roxbury. By June, they had a plan to contact a carefully selected group of citizens to find out what they perceived their health needs to be and then to analyze the data. Dr. Osler Peterson promised to be on hand in the department of preventive and social medicine in the Quadrangle and I promised bed and board and talk on weekends in Martha's Vineyard.

When they finally arrived, it was not to talk about the Roxbury project, which was going well, but to propose a new idea. They wanted more opportunity to learn of subjects not covered in the current curriculum but of great importance to them as future doctors. Though they had had some occasional discussions of social issues in medicine and of new developments in the delivery of health services in their classes and in conversations with faculty, this group felt keenly that Harvard Medical School was not giving students enough information on problems in the general area

Carl Gorman, director of native healing sciences of the Navajo Health Authority, spoke on "Navajo Philosophy and Healing Practices" at the Medicine & Society forum of November 18, 1975.

Dr. Baumgartner, active in numerous national and international organizations promoting the involvement of medicine in the social welfare of people, is currently professor of social medicine in the department of preventive and social medicine and has been faculty advisor for the Medicine and Society Forum since 1967.

of "community" or "social" medicine. They wanted to understand the problems, hear opposing views of controversial issues, and meet people both in and outside the faculty who were involved in finding new solutions. They finally suggested that these needs would be met, in part, by a series of forums — with short presentations by "experts" and a long discussion period — coupled with small student-faculty dinners preceding and a social hour following so that those most interested could continue their discussion. They wanted a student committee to select the speakers and student moderators. They wanted abundant time to argue back, to ask questions. They yearned to know faculty more intimately.

The weekend produced a proposal, including a budget. This was forwarded to the Dean who authorized the idea of the student-faculty forums and a budget for the first year. The new venture was called Medicine and Society.

The mechanics have been kept as simple as possible. All students are asked to join a planning committee and usually twelve to twenty are active, electing a chairman and vice chairman from among themselves. The group has been meeting for Sunday brunch at my home for several years. The original plan for the forums has, with modifications, been adhered to; an early sharing of food with the speaker and any faculty who come (there have been few), a forum at 6:45 with no more than thirty minutes of talks by experts — and an hour and a half or so for discussion followed by beer, cheese, and crackers and more questions has seemed to satisfy most. The atmosphere is informal. Students who want have a chance "at" the speaker. Some stayed as late as four in the morning for Saul Alinsky and Joe English!! The budget now runs from $1,200 to $1,800, the most expensive item being food — which is being dropped for 1975-76.

The medical area *Newsletter/Focus*, blackboard and oral announcements, posters and postcards have been the chief means of publicity. Depending on the topic in part, different groups of students, sometimes public health and dental students, nurses and social workers, college students, political activists, community people may attend. It has been almost impossible to predict attendance, which has varied from twenty-five to an overflowing auditorium of 250.

A total of fifty-three forums have been held in the past seven years, from five to fifteen each year. The institutions from which our speakers came can be broken down as follows:

Harvard (all schools)	31
Other universities	14
Non-universities (foundations, citizen groups, etc.)	20
Federal government	12
City government	2
State government	1
England and British Health Services	1
	81

Speakers included many medical and non-medical experts — each with something special to say on the topic chosen by the students. It has been an odd mixture: Ralph Nader, the presidents of the American and National Medical Associations, John Gardiner, Dr. Joseph English of the Office of Economic Opportunity, Saul Alinsky and Dr. John Weir of Foundations, Barbara Castle, Secretary of State for Social Services of Great Britain, Daniel Moynihan then of Harvard and later Ambassador to India and the U.N., several heads of important federal health bureaus, representatives of minority groups and citizens, academicians from many schools and disciplines, and the Dean of HMS. The criteria used to choose these men and women were their knowledge and experience in the particular fields they were to discuss. Most were able speakers — but if they were not the audience usually brought out the pertinent points they had overlooked.

The topics are somewhat more difficult to analyze, for some can fall into more than one category. Almost all were related to subjects under public or professional discussion at the time, and some preceded widespread public debate. All were chosen by the student planning committee with some help from the faculty advisor. The following seems a reasonable classification of the subject discussed.

changes in our health care system, including national health insurance	15
ethics and human experimentation	9
health manpower — problems, proposed solutions	6
acute medical-social problems such as rape, drugs, alcohol	4
from the consumer's point of view	6
environmental and occupational health problems	4
medical care elsewhere in the world	5
nutrition	2
the drug industry	2
	53

The first group of students organizing these meetings consisted of: F. John Clarke, Peter Camfield, Patchen Dellinger, Joseph Albeck, James Tenney, all of the class of 1970. Among those more active in later years have been Debbie Frank, Phillip Pittman, Noah Harris, Barbara Abercrombie, Roger Barkin, Les Schlessinger and Stefan Kruszewski. In 1975 Jim Rippe '79 suggested a new idea that he may try out this year: to choose a topic of social concern to him, develop it independently, and present it at a forum in the spring. It is hoped others will follow.

Finally *Medicine and Society* has become well enough known that the department of preventive and social medicine and the School of Public Health are formally recognizing it by setting up a joint committee to oversee its future. It might become an elective course, who knows — but in the meantime a group of Harvard medical, public health, and dental students have found a way to satisfy one of their "felt" needs — and have taken the responsibility of doing the job themselves.

Who shall say students have lost initiative?

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Nancy and the Stranger

by Howard N. Simpson '35

Daybreak came stealthily, with phantom grays;
The lonely land shrugged off its swarthy cape;
The softness of September blurred the shape
Of Indiana in the brightening haze.
The fog along the river bottom lay
A sleeping giant, elbows in the bed;
Dawn plucked his sleeve, raised up his drowsy head;
Unwillingly he rose and slouched away.
High on the bank a single wisp of smoke
From one lone chimney melted in the sky.
Inside the hut, awakening with a sigh,
A man arose and gave the fire a poke.

The day began, and in the cabin stirred
The man, his wife, a daughter and a son.
Four, welded by the wilderness in one
They went about their chores without a word.
The man had work to do that somber day;
The sort of work that tightened up his throat,
Clutched at his chest beneath his homespun coat,
Gripped at his lungs and took his breath away.
He had two graves to dig, two shallow graves,
A man and wife — the only neighbors near —
These desolate few remain to shed a tear
As drops of rain in sullen ocean waves.
He chose a little knoll that had been theirs;
The autumn sun is golden as it sets
And prints upon the sky four silhouettes
That meld in one while Nancy murmurs prayers.
The tight-lipped family trudged down the slope
Engulfed by shadows and by solitude,
Until, at home, the cheering fire renewed,
A little bit, their frontier faith and hope.

The night was black. The fog was on the creek.
Nancy lay long awake. What was life worth
If all it brought was just a mound of earth,
Windswept, a howling dog, an owl's shriek?
But she will not for long abide despair;
Stout-hearted, steady, gentle in her smile,
Facing the future calmly all the while,
Her dark eyes flash beneath her chestnut hair.
Tom is the restless, roving pioneer.
His hair is jet and long, his cheek-bones high,
Thick in the shoulder, sturdy in the thigh,
Quick of decision and devoid of fear.
Sarah, eleven, singing as she goes
To make her humble bed, to sweep, to cook,
To dream perhaps, of nights when she will look
Into the smouldering eyes of fervent beaus.
The boy is nine, awkward and strong and tall;
Handy by now in all the useful knacks
Of pioneers — the masters of the axe —
And skilled to place a wedge, or swing a maul.

The morning dawned, the dew-drenched woods were still,
The eastern sky was now with red aflame,
Restoring spirits as the daylight came —
Only that Nancy wakened with a chill.
Sarah was anxious as the fever rose.
She watched the retchings and the cramps set in
And brewed from herbs some simple medicine
Tradition said was helpful for "the slows,"
Or called "the milk-sick," recognized with dread
By midwest settlers who paid no heed
That growing in their pastures was a weed
That poisoned milk of cattle while they fed.
Those days became a week; one afternoon
Tom and the boy were burning slash and stubble,
Sarah had gone for water, all her trouble
Weighing her down, a child grown up too soon.
Nancy lay all alone inside the hut,
Racked with a fever, agonized with pain,
Her body tortured as if an iron chain
Had bound her tight. The cabin door was shut.

Suddenly she awakened from a dream —
A nightmare — felt a grateful cooling breeze
As if she lay beneath high vaulted trees
Beside the muted music of a stream.
The door swung open and a man appeared,
A Stranger, gaunt and old, hair white and thin,
A pointed nose above a pointed chin,
His weathered face was leathery and seared.
The old man rubbed his hands before the fire,
Covetous his glance from deep-set eyes aglitter,
Yet with a smile more sad perhaps than bitter,
The countenance of hunger and desire.
Nancy sat upright, weak but unafraid;
Everything swam before her in the room,
She fought to overcome delirium,
The Stranger turned, his face now in the shade.
"Why are you back so soon? It's just a week."
She drove her fist with fury in the bed.
The old man pondered what the woman said;
A moment passed, but still he didn't speak.
Her eyes were blazing and her voice was high,
"How can we clear the land or plow the plain
When you come back again, again, again?"
The Stranger flushed, and with a little sigh,
"I've come to take the boy," he then replied.
"No! No! Take me!" Perhaps the Stranger winced,
Appeared for just a moment unconvinced,
And then he nodded, seeming satisfied.

"A deal it is," he said, "I'll come tonight."
So Nancy closed her eyes and said a prayer,
And when she looked again he wasn't there
And all was silent in the waning light.
Relieved, she went to sleep, the pain was gone.
The family had returned when she awoke,
But no one moved, and no one even spoke,
The frightened boy, and Sarah, looking wan,
Tom Lincoln kneeling on the earthen floor.
"Take care of Abe," she said. Her eyes grew dim.
"This country's going to need the likes of him."
The Stranger stepped inside the cabin door.

Poetry has been a lifetime avocation for Dr. Simpson, a recently retired internist in Springfield, Massachusetts. Fact and fantasy mingle in this poem about the Lincolns.

Letters

The women's issue makes a splash

Just a line to say how much I enjoyed the women's issue of the *Harvard Medical Alumni Bulletin*. Though seasoned with humor, every line rang true. I promptly passed my issue on to a pre-medical student at Radcliffe, and have little doubt that the entire issue will be dog-eared by attentive and appreciative medical women.

Janet W. McArthur, M.D.
Boston, Massachusetts

I read with great interest your September/October *Harvard Medical Alumni/ae Bulletin*. The whole issue is very frank, accurate, and exceedingly well done. I have recommended it to several people around Yale, including our associate provost, Jackie Mintz.

I sincerely hope that this factual, thoughtful reporting reaches the correct people and stimulates them to rectify some of the many "inequalities" expressed both by themselves and by their associates, toward "women" in general.

H. Catherine Skinner, Ph.D.
Yale School of Medicine

I believe that this is the second time I have ever written a "letter to the editor." The first time was in connection with the Phi Beta Kappa magazine, *The American Scholar*. That was to express my feelings in regard to the dreadful poems that it often prints.

Letter number two is merely to say that I have enjoyed the *Harvard Medical Alumni Bulletin* tremendously the last few years. It is one of my very favorite magazines. That made me sad to come across the article in the current number [September/October] by Mary P. Rowe. Her favorite word is "paranoid." This should not be surprising, for I believe that she is as paranoid as anybody I have ever read about. I started to say that the article suggested to me some sort of "mental masturbation." I assure you that I will continue to read the magazine and that I will enjoy it very much. Please forgive an ancient alumnus for expressing a simple opinion.

Harold A. Patterson '25
New York, New York

I read and really appreciated your article ["The Saturn's Rings Phenomenon" by Mary P. Rowe, Ph.D.] in the women in medicine issue. Each of us has a collection of small slights and insults which loom large and contribute to our low opinion of ourselves, but you have been able to bring it into the open and pull it all together.

Sonya K. Gross, Ph.D.
Watertown, Massachusetts

It is regrettable that the message that appears to be carried by your September/October 1975 issue is that women are having a difficult time in medicine, not only because of their divided loyalties and responsibilities professionally and in the home but because of derisive behavior and lack of respect and loyalty from their male colleagues.

I think a voice should be heard from a woman physician who disagrees emphatically with this point of view. In the twenty-two years since I entered medical school I can say unequivocally that I have been treated with the greatest respect and courtesy by my male colleagues, both in their capacity as teachers and later as professional colleagues. I have never encountered hostility, sarcastic or inappropriate comments, degrading suggestions or behavior calculated consciously or unconsciously to humiliate me. It is more likely that my being a woman helped rather than hindered my progress in medical school and may have led to a slight leaning in my favor when it came to the treatment I received by my many instructors and professors. Similarly, I was treated with great courtesy, respect, and consideration while I was a physician in training at several different hospitals in and outside the Boston area. Finally, in the many years that I have been associated with Harvard Medical School and other teaching institutions as a member of the teaching faculty and in private practice, I have been treated as a professionally competent physician rather than as someone of lesser stature than her male colleagues or as someone who may represent a threat to them, and there appears to be very little awareness in day to day encounters, of my sex. Most importantly, it is the respect, loyalty, and intellectual stimulation from my many male colleagues in medicine that make my profession the satisfying and rewarding experience it has always been.

As I have told the many women who have come to ask me about careers in medicine or whom I have interviewed in my capacity as a member of the admissions committee at Harvard Medical School, women who enter the profession of medicine and plan to marry and have children must recognize that they will have a double burden to carry. It is the traditional responsibility of the female to be a wife to her husband and a mother to her children, a serious responsibility which weighs heavily on every woman who is combining motherhood with a professional career. There is no way to deny this responsibility and each woman has to come to terms with the problem in her own particular fashion. No matter what solution she finds, she will always be torn between two conflicting responsibilities, which at times are mutually incompatible. There will be times when she will not be able to give her best to one in order to give her best to the other, and there are inevitably days when she will feel that she is letting someone down. This is in the nature of things and something each woman has to accept before she enters any professional career. A woman physician has to face the fact that she will work harder than her male colleagues if she is to do justice to her role as a physician and as a wife and mother, and she has to accept this fact with grace and without bitterness and rancor.

It is a great credit to my husband and children that they have endured living with a mother who has always worked full time. My hours are long and I am often exhausted, irritable, and distracted in the evenings when I finally join my family. They have tolerated this fatigue, irritability, and distraction with cheerfulness, good humor, and understanding. No woman can work effec-

tively as a physician without this kind of support from her husband and her children, and I will forever be grateful to my family for providing me with such support.

It has become fashionable for minority groups to clamor for recognition and special treatment and to some extent this is understandable and long overdue. I feel that in the process some members of such minority groups, including women, have lost their sense of balance as well as their sense of humor. I do not take it amiss if I am mistaken for a grocery clerk in supermarkets. What else is one to expect from the American public who will see several thousand grocery clerks in white before they will encounter a single woman physician in white, unless she dangles a stethoscope self-consciously around her neck? If a sense of balance and proportion can be maintained, I am sure that all my colleagues would agree with me that there is no more satisfying and exciting profession for a woman than medicine, and no profession that rewards her with an equal degree of recognition and respect for her long hours of service.

Dorothea Hellman '57
Tucson, Arizona

Rummaging through the trash . . .

I have never been one to withhold comment — on anything. This time it is to note that the *Harvard Medical Alumni Bulletin*, which I receive through the trash basket of one of your graduates, rates almost at the top of my grading scale for readability, pertinence, and significance. The index I use is the number of articles I tear out of each issue for use, for or against somebody or thing.

While I have never been overwhelmed by HMS, I fear that is due to jealousy, well founded. There just isn't another HMS, thank Heaven. But it is tops in my book much to my regret. And while I am on the subject, I read and *still* enjoy [Dean Ebert's] valedictions.

Irvine H. Page, M.D.
The Cleveland Clinic